

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/23/2023 11:46 am
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PART I - COST REPORT STATUS

Provider use only 1. Electronically prepared cost report Date: 5/23/2023 Time: 11:46 am
 2. Manually prepared cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

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

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 REID HOSPITAL & HEALTH CARE SERVICES (15-0048) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

	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	-43,215	805,013	0	0 1.00
2.00	SUBPROVIDER - IPF	0	63,267	2	0	0 2.00
3.00	SUBPROVIDER - IRF	0	8,525	1	0	0 3.00
5.00	SWING BED - SNF	0	0	0	0	0 5.00
6.00	SWING BED - NF	0			0	0 6.00
200.00	TOTAL	0	28,577	805,016	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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-MEDI CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/23/2023 11:46 am
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1.00	2.00	3.00	4.00	1.00
Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1401 CHESTER BOULEVARD	PO Box:	Zip Code: 47374	County: WAYNE
2.00	City: RICHMOND	State: IN		

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
						V	XVIII	XIX	
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		

Hospital and Hospital-Based Component Identification:										
3.00	Hospital	REID HOSPITAL & HEALTH CARE SERVICES	150048	99915	1	07/01/1966	N	P	0	3.00
4.00	Subprovider - IPF	SUBPROVIDER	15S048	99915	4	01/01/2001	N	P	0	4.00
5.00	Subprovider - IRF	REHAB UNIT	15T048	99915	5	01/01/2003	N	P	0	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	HOSPICE	151524	99915		11/03/1993				14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:		
						1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2022	12/31/2022	20.00	
21.00	Type of Control (see instructions)					2		21.00	
						1.00	2.00	3.00	

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0048			Period: From 01/01/2022 To 12/31/2022		Worksheet S-2 Part I Date/Time Prepared: 5/23/2023 11:46 am			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	956	640	508	103	8,505	112		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	94	10	47	428			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.					2			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.					2			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.					1			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.					01/01/2022		12/31/2022	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)					Y		N	40.00	
						V	XVIII	XIX		
						1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital										
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N		N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N		N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N		N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N		N	N	48.00
Teaching Hospitals										
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you 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	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.					Y				57.00

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		V	XVIII	XIX		
		1.00	2.00	3.00		
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.	Y	Y			60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1		60.01
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).					61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)					61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)					61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
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
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings 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)				Y	63.00

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			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col . 1/ (col . 1 + col . 2))			
			1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000		64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col . 3/ (col . 3 + col . 4))		
		1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col . 1/ (col . 1 + col . 2))			
			1.00	2.00	3.00			
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000		66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col . 3/ (col . 3 + col . 4))		
		1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	FAMILY MED	1350	2.03	14.34	0.124007		67.00

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			1.00		
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?		N		68.00
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		Y		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
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.		Y		75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)		N	N	0
			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
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
			1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.				0
			1.00	2.00	3.00
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.		0.00		0
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00

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		V	XIX		
		1.00	2.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. 1, 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. 1? 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. 1V, 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. 1, 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. 1 through 1V? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical 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	N	N
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00
				1.00	2.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.		N		111.00
				1.00	2.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
113.00	Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.				113.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/23/2023 11:46 am	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N	118.02	
119.00	DO NOT USE THIS LINE			119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		Y	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		Y	5.06	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.				123.00
Certified Transplant Center Information					
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	Removed and reserved				133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		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: REID HOME OFFICE	Contractor's Name: WPS		Contractor's Number: 08101	141.00
142.00	Street: 1100 REID PARKWAY	PO Box:			142.00
143.00	City: RICHMOND	State: IN		Zip Code: 47374	143.00
			1.00		
144.00	Are provider based physicians' costs included in Worksheet A?		Y		144.00
			1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.		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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0048		Period: From 01/01/2022 To 12/31/2022		Worksheet S-2 Part II Date/Time Prepared: 5/23/2023 11:46 am	
				Y/N	Date		
				1.00	2.00		
PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE							
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/20/2023			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					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.	Y					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 coinsurance amounts waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/03/2023	Y	04/03/2023		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/23/2023 11:46 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been 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			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			Y	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.			Y	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.			Y	33.00
Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	KERRY		BEJARANO	41.00
42.00	Enter the employer/company name of the cost report preparer.	FORVIS			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3173834000		KERRY.BEJARANO@FORVIS.COM	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.	DI RECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet S-3
Part I
Date/Time Prepared:
5/23/2023 11:46 am

Component	Worksheet A Line No.	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	153	55,845	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)		153	55,845	0.00	0 7.00
8.00	INTENSIVE CARE UNIT	31.00	30	10,950	0.00	0 8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY	43.00				0 13.00
14.00	Total (see instructions)		183	66,795	0.00	0 14.00
15.00	CAH visits					0 15.00
16.00	SUBPROVIDER - IPF	40.00	0	9,408		0 16.00
17.00	SUBPROVIDER - IRF	41.00	20	7,300		0 17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE	116.00	0	0		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)		203			27.00
28.00	Observation Bed Days					0 28.00
29.00	Ambulance Trips					29.00
30.00	Employee discount days (see instruction)					30.00
31.00	Employee discount days - IRF					31.00
32.00	Labor & delivery days (see instructions)		0	0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)					32.01
33.00	LTCH non-covered days					33.00
33.01	LTCH site neutral days and discharges					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0 34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA	Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part I Date/Time Prepared: 5/23/2023 11:46 am
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Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	14,946	759	36,117		1.00
2.00	HMO and other (see instructions)	8,287	9,756			2.00
3.00	HMO IPF Subprovider	1,344	506			3.00
4.00	HMO IRF Subprovider	787	579			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)	14,946	759	36,117		7.00
8.00	INTENSIVE CARE UNIT	1,904	101	5,037		8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY		96	1,417		13.00
14.00	Total (see instructions)	16,850	956	42,571	16.37	14.00
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF	1,864	215	4,631	0.00	16.00
17.00	SUBPROVIDER - IRF	1,643	0	3,810	0.00	17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE	1,390	33	1,735	0.00	24.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.25
27.00	Total (sum of lines 14-26)				16.37	27.00
28.00	Observation Bed Days		234	7,155		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			436		30.00
31.00	Employee discount days - IRF			39		31.00
32.00	Labor & delivery days (see instructions)	0	112	175		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0		34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA	Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part I Date/Time Prepared: 5/23/2023 11:46 am
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Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	4,604	243	10,834	1.00
2.00	HMO and other (see instructions)			1,926	2,483		2.00
3.00	HMO IPF Subprovider				56		3.00
4.00	HMO IRF Subprovider				40		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	4,604	243	10,834	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	191	0	511	16.00
17.00	SUBPROVIDER - IRF	0.00	0	133	0	263	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet S-3
Part II
Date/Time Prepared:
5/23/2023 11:46 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	110,917,961	0	110,917,961	3,454,965.87	32.10
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	2,004,328	2,004,328	39,462.79	50.79
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		7,484,913	781,830	8,266,743	255,237.22	32.39
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		12,548,243	0	12,548,243	164,806.03	76.14
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		442,438	0	442,438	2,788.25	158.68
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		22,020,964	0	22,020,964	674,622.05	32.64
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		30,895,237	0	30,895,237		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		2,495,273	0	2,495,273		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		385,795	0	385,795		
25.50	Home office wage-related (core)		3,932,543	0	3,932,543		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet S-3
Part II
Date/Time Prepared:
5/23/2023 11:46 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	234,865	0	234,865	8,408.00	27.93	26.00
27.00	Administrative & General	5.00	10,181,587	268,876	10,450,463	442,002.37	23.64	27.00
28.00	Administrative & General under contract (see inst.)		6,951,077	0	6,951,077	102,990.96	67.49	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	615,011	-95,536	519,475	29,048.16	17.88	31.00
32.00	Housekeeping	9.00	2,875,641	0	2,875,641	148,600.85	19.35	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	3,588,455	-2,410,409	1,178,046	59,520.62	19.79	34.00
35.00	Dietary under contract (see instructions)		387,693	0	387,693	5,347.00	72.51	35.00
36.00	Cafeteria	11.00	0	2,410,409	2,410,409	120,842.68	19.95	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	323,913	323,913	2,080.00	155.73	38.00
39.00	Central Services and Supply	14.00	609,997	0	609,997	32,194.01	18.95	39.00
40.00	Pharmacy	15.00	4,824,693	0	4,824,693	126,964.74	38.00	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	5,086,701	0	5,086,701	140,180.93	36.29	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 15-0048		Period: From 01/01/2022 To 12/31/2022		Worksheet S-3 Part III Date/Time Prepared: 5/23/2023 11:46 am	
	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART III - HOSPITAL WAGE INDEX SUMMARY								
1.00	Net salaries (see instructions)	118,256,731	-2,004,328	116,252,403	3,523,841.04	32.99		1.00
2.00	Excluded area salaries (see instructions)	7,484,913	781,830	8,266,743	255,237.22	32.39		2.00
3.00	Subtotal salaries (line 1 minus line 2)	110,771,818	-2,786,158	107,985,660	3,268,603.82	33.04		3.00
4.00	Subtotal other wages & related costs (see inst.)	35,011,645	0	35,011,645	842,216.33	41.57		4.00
5.00	Subtotal wage-related costs (see inst.)	34,827,780	0	34,827,780	0.00	32.25		5.00
6.00	Total (sum of lines 3 thru 5)	180,611,243	-2,786,158	177,825,085	4,110,820.15	43.26		6.00
7.00	Total overhead cost (see instructions)	35,355,720	497,253	35,852,973	1,218,180.32	29.43		7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part IV Date/Time Prepared: 5/23/2023 11:46 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			233,361 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			4,133,619 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			0 8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)			0 8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)			18,775,281 8.02
8.03	Health Insurance (Purchased)			0 8.03
9.00	Prescription Drug Plan			76,055 9.00
10.00	Dental, Hearing and Vision Plan			652,574 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			150,508 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)			375,877 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			816,676 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)			0 16.00
TAXES				
17.00	FICA-Employers Portion Only			8,315,464 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			0 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			246,890 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			33,776,305 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part V Date/Time Prepared: 5/23/2023 11:46 am
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	12,548,243	33,776,305	1.00
2.00	Hospital	12,548,243	31,281,032	2.00
3.00	SUBPROVIDER - IPF	0	840,408	3.00
4.00	SUBPROVIDER - IRF	0	611,591	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice	0	780,771	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	262,503	18.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-0048
Hospice CCN: 15-1524

Period:
From 01/01/2022
To 12/31/2022

Worksheet S-9
PARTS I THROUGH IV
Date/Time Prepared:
5/23/2023 11:46 am

		Hospice I						
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	17,310	86	1,685	19,081	11.00
12.00	Hospice Inpatient Respite Care	150	0	16	166	12.00
13.00	Hospice General Inpatient Care	1,240	33	296	1,569	13.00
14.00	Total Hospice Days	18,700	119	1,997	20,816	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet S-10 Date/Time Prepared: 5/23/2023 11:46 am	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.297406	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			61,362,425	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			232,661,267	6.00
7.00	Medicaid cost (line 1 times line 6)			69,194,857	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)			7,832,432	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)			7,832,432	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,885,201	2,731,332	4,616,533	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	560,670	2,731,332	3,292,002	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	560,670	2,731,332	3,292,002	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			16,833,673	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			2,338,357	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			3,597,472	27.01
28.00	Non-Medicare bad debt expense (see instructions)			13,236,201	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			5,195,641	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			8,487,643	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			16,320,075	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 15-0048		Period: From 01/01/2022 To 12/31/2022		Worksheet A	
Date/Time Prepared: 5/23/2023 11:46 am								
Cost Center	Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	22,448,378	22,448,378	1.00	
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE	0	0	7,994,001	7,994,001	1.01	
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	234,865	30,439	265,304	-3,113	4.00	262,191
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	5.01	0
5.02	00550	DATA PROCESSING	230,277	2,755,249	2,985,526	0	5.02	2,985,526
5.03	00560	PURCHASING RECEIVING AND STORES	75,178	14,695	89,873	0	5.03	89,873
5.04	00570	ADMINISTRATION	5,930,442	2,537,038	8,467,480	-15,193	5.04	8,452,287
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	268,712	268,712	-164,144	5.05	104,568
5.06	00590	OTHER A&G	3,945,690	22,739,159	26,684,849	-11,142	5.06	26,673,707
7.00	00700	OPERATION OF PLANT	0	0	0	0	7.00	0
8.00	00800	LAUNDRY & LINEN SERVICE	615,011	629,462	1,244,473	-178,743	8.00	1,065,730
9.00	00900	HOUSEKEEPING	2,875,641	1,081,001	3,956,642	0	9.00	3,956,642
10.00	01000	DIETARY	3,588,455	4,331,706	7,920,161	-5,295,571	10.00	2,624,590
11.00	01100	CAFETERIA	0	0	0	5,294,675	11.00	5,294,675
13.00	01300	NURSING ADMINISTRATION	0	0	0	323,913	13.00	323,913
14.00	01400	CENTRAL SERVICES & SUPPLY	609,997	5,766,011	6,376,008	0	14.00	6,376,008
15.00	01500	PHARMACY	4,824,693	40,423,579	45,248,272	-11,514	15.00	45,236,758
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00	0
17.00	01700	SOCIAL SERVICE	3,657,098	625,035	4,282,133	0	17.00	4,282,133
17.01	01701	INSERVICE EDUCATION	1,429,603	1,779,378	3,208,981	0	17.01	3,208,981
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	2,089,254	21.00	2,089,254
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,102,498	628,433	2,730,931	-2,089,254	22.00	641,677
23.00	02300	PARAMED PRGM	285,110	55,339	340,449	0	23.00	340,449
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	25,576,622	13,614,720	39,191,342	-916,328	30.00	38,275,014
31.00	03100	INTENSIVE CARE UNIT	4,378,887	2,495,759	6,874,646	0	31.00	6,874,646
40.00	04000	SUBPROVIDER - I PF	2,256,259	376,258	2,632,517	0	40.00	2,632,517
41.00	04100	SUBPROVIDER - I RF	1,641,909	392,860	2,034,769	0	41.00	2,034,769
43.00	04300	NURSERY	599,946	134,931	734,877	0	43.00	734,877
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,850,204	53,376,762	55,226,966	-12,838,549	50.00	42,388,417
52.00	05200	DELIVERY ROOM & LABOR ROOM	635,566	289,799	925,365	-920	52.00	924,445
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,613,073	12,394,544	21,007,617	-92,357	54.00	20,915,260
59.00	05900	CARDIAC CATHETERIZATION	2,221,045	13,056,795	15,277,840	-6,531,538	59.00	8,746,302
60.00	06000	LABORATORY	5,329,975	11,896,662	17,226,637	-51,119	60.00	17,175,518
65.00	06500	RESPIRATORY THERAPY	1,786,568	1,628,414	3,414,982	-937	65.00	3,414,045
66.00	06600	PHYSICAL THERAPY	8,504,540	2,759,340	11,263,880	-251,625	66.00	11,012,255
69.00	06900	ELECTROCARDIOLOGY	1,440,272	1,643,438	3,083,710	0	69.00	3,083,710
70.00	07000	ELECTROENCEPHALOGRAPHY	459,280	154,552	613,832	-744	70.00	613,088
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19,381,532	72.00	19,381,532
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00	0
74.00	07400	RENAL DIALYSIS	532	932,852	933,384	0	74.00	933,384
76.00	03950	ANCILLARY - OTHER	0	0	0	0	76.00	0
76.97	07697	CARDIAC REHABILITATION	512,214	117,699	629,913	-18,854	76.97	611,059
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00	0
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	9,250,890	5,465,466	14,716,356	-955,880	91.00	13,760,476
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00	
93.00	04040	FAMILY PRACTICE	1,863,561	545,089	2,408,650	-87,405	93.00	2,321,245
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	290,425	492,464	782,889	0	96.00	782,889
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00	0
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		8,730,057	8,730,057	-8,730,057	113.00	0
116.00	11600	HOSPICE	1,410,225	1,352,655	2,762,880	783,990	116.00	3,546,870
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	109,026,551	215,516,352	324,542,903	20,070,756	118.00	344,613,659
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,072,334	12,072,334	-6,982,991	192.00	5,089,343
194.00	07950	RENTAL SPACE	0	18,190,679	18,190,679	-12,261,967	194.00	5,928,712
194.01	07951	FOUNDATION	155,142	183,996	339,138	0	194.01	339,138
194.02	07952	RETAIL SERVICES	168,485	25,333	193,818	0	194.02	193,818
194.03	07953	REID CONTRACTED SERVICES	0	0	0	178,743	194.03	178,743
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	194.04	0
194.05	07955	CONNERSVILLE LOCATION	0	1,939,882	1,939,882	-482,583	194.05	1,457,299
194.06	07956	VACANT SPACE	0	756,946	756,946	-516,387	194.06	240,559
194.07	07957	HOME OFFICE	0	0	0	0	194.07	0
194.08	07958	CAMBRI DGE RHC	0	0	0	0	194.08	0
194.09	07959	REID HEALTH PAVILION - RES	1,567,783	301,594	1,869,377	-5,571	194.09	1,863,806

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0048		Period: From 01/01/2022 To 12/31/2022		Worksheet A Date/Time Prepared: 5/23/2023 11:46 am	
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
200.00	TOTAL (SUM OF LINES 118 through 199)	110,917,961	248,987,116	359,905,077	0	359,905,077	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet A
Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,399,633	23,848,011	1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE	0	7,994,001	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	21,452,656	21,714,847	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	5.01
5.02	00550	DATA PROCESSING	16,618,868	19,604,394	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	89,873	5.03
5.04	00570	ADMITTING	-22	8,452,265	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	-104,568	0	5.05
5.06	00590	OTHER A&G	13,281,521	39,955,228	5.06
7.00	00700	OPERATION OF PLANT	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-137,804	927,926	8.00
9.00	00900	HOUSEKEEPING	-879	3,955,763	9.00
10.00	01000	DIETARY	-256,161	2,368,429	10.00
11.00	01100	CAFETERIA	-3,530,850	1,763,825	11.00
13.00	01300	NURSING ADMINISTRATION	0	323,913	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-8	6,376,000	14.00
15.00	01500	PHARMACY	-137,196	45,099,562	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
17.00	01700	SOCIAL SERVICE	4,064	4,286,197	17.00
17.01	01701	INSERVICE EDUCATION	-624,736	2,584,245	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	2,089,254	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-331,341	310,336	22.00
23.00	02300	PARAMED ED PRGM	-57,602	282,847	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-6,315,663	31,959,351	30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,874,646	31.00
40.00	04000	SUBPROVIDER - IPF	-28	2,632,489	40.00
41.00	04100	SUBPROVIDER - IRF	-151,434	1,883,335	41.00
43.00	04300	NURSERY	-1,999	732,878	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-10,786,339	31,602,078	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-68	924,377	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-943,765	19,971,495	54.00
59.00	05900	CARDIAC CATHETERIZATION	-1,010	8,745,292	59.00
60.00	06000	LABORATORY	-1,433,644	15,741,874	60.00
65.00	06500	RESPIRATORY THERAPY	-630	3,413,415	65.00
66.00	06600	PHYSICAL THERAPY	-160,749	10,851,506	66.00
69.00	06900	ELECTROCARDIOLOGY	-43,422	3,040,288	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-520	612,568	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	19,381,532	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	933,384	74.00
76.00	03950	ANCILLARY - OTHER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	611,059	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-2,679,628	11,080,848	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04040	FAMILY PRACTICE	-12,843	2,308,402	93.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	-467,462	315,427	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	-40,593	3,506,277	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,535,778	369,149,437	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,089,343	192.00
194.00	07950	RENTAL SPACE	0	5,928,712	194.00
194.01	07951	FOUNDATION	0	339,138	194.01
194.02	07952	RETAIL SERVICES	0	193,818	194.02
194.03	07953	REID CONTRACTED SERVICES	0	178,743	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	1,457,299	194.05
194.06	07956	VACANT SPACE	0	240,559	194.06
194.07	07957	HOME OFFICE	0	0	194.07
194.08	07958	CAMBRI DGE RHC	0	0	194.08
194.09	07959	REID HEALTH PAVILION - RES	0	1,863,806	194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	24,535,778	384,440,855	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAPITAL EXPENSE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	13,421,794	1.00
2.00	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	7,554,218	2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	78,333	3.00
4.00	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	437,403	4.00
5.00	CAP REL COSTS-BLDG & FIXT	1.00	0	218,194	5.00
6.00	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	2,380	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
			0	21,712,322	
B - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	2,410,409	2,884,266	1.00
			2,410,409	2,884,266	
C - LAUNDRY RECLASS					
1.00	REID CONTRACTED SERVICES	194.03	95,536	83,207	1.00
			95,536	83,207	
D - NURSING VP RECLASS					
1.00	NURSING ADMINISTRATION	13.00	323,913	0	1.00
			323,913	0	
E - OCCUPATIONAL MEDICINE RECLASS					
1.00	OTHER A&G	5.06	592,789	354,866	1.00
			592,789	354,866	
F - IMPLANTABLE DEVICES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	19,381,532	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
			0	19,381,532	
G - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,730,057	1.00
			0	8,730,057	
J - INTERN AND RESIDENT					
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	2,004,328	84,926	1.00
			2,004,328	84,926	
N - HOSPICE					
1.00	HOSPICE	116.00	686,294	99,346	1.00
			686,294	99,346	
500.00	Grand Total: Increases		6,113,269	53,330,522	500.00

RECLASSIFICATIONS

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet A-6
Date/Time Prepared:
5/23/2023 11:46 am

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - CAPITAL EXPENSE RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,113	9	1.00
2.00	ADMINISTRATIVE	5.04	0	15,193	9	2.00
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	164,144	13	3.00
4.00	OTHER A&G	5.06	0	634,884	13	4.00
5.00	DIETARY	10.00	0	896	10	5.00
6.00	PHARMACY	15.00	0	11,514	10	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	130,688	0	7.00
8.00	OPERATING ROOM	50.00	0	12,809	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	69,023	0	9.00
10.00	LABORATORY	60.00	0	51,119	0	10.00
11.00	RESPIRATORY THERAPY	65.00	0	937	0	11.00
12.00	PHYSICAL THERAPY	66.00	0	251,625	0	12.00
13.00	ELECTROENCEPHALOGRAPHY	70.00	0	744	0	13.00
14.00	CARDIAC REHABILITATION	76.97	0	18,854	0	14.00
15.00	EMERGENCY	91.00	0	8,225	0	15.00
16.00	FAMILY PRACTICE	93.00	0	87,405	0	16.00
17.00	HOSPICE	116.00	0	1,650	0	17.00
18.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	6,982,991	0	18.00
19.00	RENTAL SPACE	194.00	0	12,261,967	0	19.00
20.00	CONNERSVILLE LOCATION	194.05	0	482,583	0	20.00
21.00	VACANT SPACE	194.06	0	516,387	0	21.00
22.00	REID HEALTH PAVILION - RES	194.09	0	5,571	0	22.00
			0	21,712,322		
B - CAFETERIA RECLASS						
1.00	DIETARY	10.00	2,410,409	2,884,266	0	1.00
			2,410,409	2,884,266		
C - LAUNDRY RECLASS						
1.00	LAUNDRY & LINEN SERVICE	8.00	95,536	83,207	0	1.00
			95,536	83,207		
D - NURSING VP RECLASS						
1.00	OTHER A&G	5.06	323,913	0	0	1.00
			323,913	0		
E - OCCUPATIONAL MEDICINE RECLASS						
1.00	EMERGENCY	91.00	592,789	354,866	0	1.00
			592,789	354,866		
F - IMPLANTABLE DEVICES RECLASS						
1.00	OPERATING ROOM	50.00	0	12,825,740	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	920	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	23,334	0	3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	6,531,538	0	4.00
			0	19,381,532		
G - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	8,730,057	11	1.00
			0	8,730,057		
J - INTERN AND RESIDENT						
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	2,004,328	84,926	0	1.00
			2,004,328	84,926		
N - HOSPICE						
1.00	ADULTS & PEDIATRICS	30.00	686,294	99,346	0	1.00
			686,294	99,346		
500.00	Grand Total: Decreases		6,113,269	53,330,522		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet A-7
Part I
Date/Time Prepared:
5/23/2023 11:46 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	18,100,042	617,354	0	617,354	0 1.00
2.00	Land Improvements	11,502,205	0	0	0	618,849 2.00
3.00	Buildings and Fixtures	333,565,568	11,039,181	0	11,039,181	0 3.00
4.00	Building Improvements	13,645,110	0	0	0	0 4.00
5.00	Fixed Equipment	2,222,588	14,510	0	14,510	0 5.00
6.00	Movable Equipment	208,123,269	12,676,460	0	12,676,460	0 6.00
7.00	HIT designated Assets	0	0	0	0	0 7.00
8.00	Subtotal (sum of lines 1-7)	587,158,782	24,347,505	0	24,347,505	618,849 8.00
9.00	Reconciling Items	0	0	0	0	0 9.00
10.00	Total (line 8 minus line 9)	587,158,782	24,347,505	0	24,347,505	618,849 10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	18,717,396	0			0 1.00
2.00	Land Improvements	10,883,356	0			0 2.00
3.00	Buildings and Fixtures	344,604,749	0			0 3.00
4.00	Building Improvements	13,645,110	0			0 4.00
5.00	Fixed Equipment	2,237,098	0			0 5.00
6.00	Movable Equipment	220,799,729	0			0 6.00
7.00	HIT designated Assets	0	0			0 7.00
8.00	Subtotal (sum of lines 1-7)	610,887,438	0			0 8.00
9.00	Reconciling Items	0	0			0 9.00
10.00	Total (line 8 minus line 9)	610,887,438	0			0 10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet A-7
Part II
Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet A-7
Part III
Date/Time Prepared:
5/23/2023 11:46 am

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	390,087,709	0	390,087,709	0.638559	0	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	220,799,729	0	220,799,729	0.361441	0	2.00
3.00	Total (sum of lines 1-2)	610,887,438	0	610,887,438	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	23,551,484	218,194	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	0	7,554,218	2,380	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	31,105,702	220,574	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	78,333	0	23,848,011	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	437,403	0	7,994,001	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	515,736	0	31,842,012	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet A-8

Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01 Investment income - NEW CAP BLDG & FIXT - OFFSITE (chapter 2)			0	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	1.01
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	0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B		0	PURCHASING RECEIVING AND STORES	5.03	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0	0	0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0	0	0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0	0	0.00	0	7.00
8.00 Television and radio service (chapter 21)			0	0	0.00	0	8.00
9.00 Parking lot (chapter 21)			0	0	0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-16,717,903				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0	0	0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	85,107,439				0	12.00
13.00 Laundry and linen service			0	0	0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-2,793,255		CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employees and others			0	0	0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients	B		0	PURCHASING RECEIVING AND STORES	5.03	0	16.00
17.00 Sale of drugs to other than patients	B	-137,196		PHARMACY	15.00	0	17.00
18.00 Sale of medical records and abstracts	B		0	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0	0	0.00	0	19.00
20.00 Vending machines	B	-256,161		DIETARY	10.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0	0	0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0	0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3			RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3			PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01 Depreciation - NEW CAP BLDG & FIXT - OFFSITE			0	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	26.01
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0	0	0.00	0	29.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet A-8

Date/Time Prepared:
5/23/2023 11:46 am

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	
30.00	A-8-3		0	*** Cost Center Deleted ***	67.00	30.00
30.99			0	ADULTS & PEDIATRICS	30.00	30.99
31.00	A-8-3		0	*** Cost Center Deleted ***	68.00	31.00
32.00			0		0.00	0 32.00
33.00	B	-109,638		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.00
33.01	B	-803,492		DATA PROCESSING	5.02	0 33.01
33.02	B			OPURCHASING RECEIVING AND STORES	5.03	0 33.02
33.03	B	-5		ADMINNING	5.04	0 33.03
33.04	B	-104,568		CASHIERING/ACCOUNTS RECEIVABLE	5.05	0 33.04
33.05	B	-28,000		OTHER A&G	5.06	0 33.05
33.06	B	-137,804		LAUNDRY & LINEN SERVICE	8.00	0 33.06
33.07	B	-737,595		CAFETERIA	11.00	0 33.07
33.08	B	4,886		SOCIAL SERVICE	17.00	0 33.08
33.09	B	-49,846		INSERVICE EDUCATION	17.01	0 33.09
33.10	B	-57,193		PARAMED PRGM	23.00	0 33.10
33.11	B	-26,132		ADULTS & PEDIATRICS	30.00	0 33.11
33.12	B	-498		OPERATING ROOM	50.00	0 33.12
33.13	B	-213,765		RADIOLOGY-DIAGNOSTIC	54.00	0 33.13
33.14	B	-24,785		LABORATORY	60.00	0 33.14
33.15	B	220		ELECTROCARDIOLOGY	69.00	0 33.15
33.16	B	-148,466		PHYSICAL THERAPY	66.00	0 33.16
33.17	B	-2,535		EMERGENCY	91.00	0 33.17
33.18	B	-465,702		DURABLE MEDICAL EQUIP-RENTED	96.00	0 33.18
33.19	B	-39,830		HOSPICE	116.00	0 33.19
33.20	B	-3,801,940		CAP REL COSTS-BLDG & FIXT	1.00	11 33.20
33.21	A	-4,928,117		CAP REL COSTS-BLDG & FIXT	1.00	11 33.21
33.22	A	-8,188,108		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.22
33.23	A	-144,539		OTHER A&G	5.06	0 33.23
33.24	A			DIETARY	10.00	0 33.24
33.25	A	-4,134		INSERVICE EDUCATION	17.01	0 33.25
33.26	A	-541		I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0 33.26
33.27	A	-250		PARAMED PRGM	23.00	0 33.27
33.28	A	-3,077		ADULTS & PEDIATRICS	30.00	0 33.28
33.29	A	-79		SUBPROVIDER - IPF	40.00	0 33.29
33.30	A	-2,953		SUBPROVIDER - IRF	41.00	0 33.30
33.31	A	-1,999		NURSERY	43.00	0 33.31
33.32	A	-733		OPERATING ROOM	50.00	0 33.32
33.33	A	-66		RADIOLOGY-DIAGNOSTIC	54.00	0 33.33
33.34	A	-1,010		CARDIAC CATHETERIZATION	59.00	0 33.34
33.35	A	-10,061		PHYSICAL THERAPY	66.00	0 33.35
33.36	A	-520		ELECTROENCEPHALOGRAPHY	70.00	0 33.36
33.37	A	-435		EMERGENCY	91.00	0 33.37
33.38	A	-10,726		FAMILY PRACTICE	93.00	0 33.38
33.39	A	-1,666		DURABLE MEDICAL EQUIP-RENTED	96.00	0 33.39
33.40	A	-618		HOSPICE	116.00	0 33.40
33.41	A	-17		ADMINNING	5.04	0 33.41
33.42	A	-862,586		OTHER A&G	5.06	0 33.42
33.43	A	-879		HOUSEKEEPING	9.00	0 33.43
33.44	A	-8		CENTRAL SERVICES & SUPPLY	14.00	0 33.44
33.45	A	-822		SOCIAL SERVICE	17.00	0 33.45
33.46	A	-319,656		INSERVICE EDUCATION	17.01	0 33.46
33.47	A	-1,050		I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0 33.47
33.48	A	-159		PARAMED PRGM	23.00	0 33.48
33.49	A	-1,591		ADULTS & PEDIATRICS	30.00	0 33.49
33.50	A	51		SUBPROVIDER - IPF	40.00	0 33.50
33.51	A	-281		SUBPROVIDER - IRF	41.00	0 33.51

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet A-8

Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
33.52 NON-ALLOWABLE EXPENSES	A	-10	OPERATING ROOM		50.00	0	33.52
33.53 NON-ALLOWABLE EXPENSES	A	-68	DELIVERY ROOM & LABOR ROOM		52.00	0	33.53
33.54 NON-ALLOWABLE EXPENSES	A	-630	RESPIRATORY THERAPY		65.00	0	33.54
33.55 NON-ALLOWABLE EXPENSES	A	-2,222	PHYSICAL THERAPY		66.00	0	33.55
33.56 NON-ALLOWABLE EXPENSES	A	-1,784	EMERGENCY		91.00	0	33.56
33.57 NON-ALLOWABLE EXPENSES	A	-2,117	FAMILY PRACTICE		93.00	0	33.57
33.58 NON-ALLOWABLE EXPENSES	A	-94	DURABLE MEDICAL EQUIP-RENTED		96.00	0	33.58
33.59 NON-ALLOWABLE EXPENSES	A	-145	HOSPICE		116.00	0	33.59
33.60 HAF EXPENSE	A	-18,179,574	OTHER A&G		5.06	0	33.60
33.61 BOND REFUNDING - 2015 BONDS	A	-401,531	OTHER A&G		5.06	0	33.61
33.62 BOND REFUNDING - 2016 BONDS	A	-7,737	OTHER A&G		5.06	0	33.62
33.63 OCC MED - EMPLOYEE COST	A	-48,378	OTHER A&G		5.06	0	33.63
33.64 OCC MED - EMPLOYEE COST	A	-785,349	LABORATORY		60.00	0	33.64
33.65 OCC MED - EMPLOYEE COST	A	-4,189	RADIOLOGY-DIAGNOSTIC		54.00	0	33.65
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		24,535,778					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: 15-0048
 Period: From 01/01/2022 To 12/31/2022
 Worksheet A-8-1
 Date/Time Prepared: 5/23/2023 11:46 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	REID OUTPATIENT SURGERY	25,847,434	31,036,564 1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL	10,129,690	0 2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	BENEFITS & HR	29,750,402	0 3.00
4.00	5.02	DATA PROCESSING	INFORMATION SYSTEMS	17,422,360	0 4.00
4.01	5.06	OTHER A&G	A&G	32,994,117	0 4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			116,144,003	31,036,564 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	A	REID O/P SURGER	55.00	0.00	6.00
7.00	B		0.00	100.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet A-8-1 Date/Time Prepared: 5/23/2023 11:46 am
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	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	-5,189,130	0		1.00
2.00	10,129,690	9		2.00
3.00	29,750,402	0		3.00
4.00	17,422,360	0		4.00
4.01	32,994,117	0		4.01
5.00	85,107,439			5.00

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

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

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

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

6.00			6.00
7.00	HOME OFFICE		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet A-8-2

Date/Time Prepared:
5/23/2023 11:46 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.06	OTHER A&G	40,251	40,251	0	179,000	0	1.00
2.00	17.01	INSERVICE EDUCATION	327,863	189,663	138,200	179,000	892	2.00
3.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	580,803	184,241	396,562	197,500	2,644	3.00
4.00	30.00	ADULTS & PEDIATRICS	6,286,154	6,283,866	2,288	179,000	15	4.00
5.00	41.00	SUBPROVIDER - IRF	148,200	148,200	0	179,000	0	5.00
6.00	50.00	OPERATING ROOM	5,595,968	5,594,468	0	246,400	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	725,745	725,745	0	260,300	0	7.00
8.00	60.00	LABORATORY	623,510	623,510	0	260,300	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	43,642	43,642	0	179,000	0	9.00
10.00	91.00	EMERGENCY	2,674,874	2,674,874	0	179,000	0	10.00
200.00			17,047,010	16,508,460	537,050		3,551	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.06	OTHER A&G	0	0	0	0	0	1.00
2.00	17.01	INSERVICE EDUCATION	76,763	3,838	0	0	0	2.00
3.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	251,053	12,553	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	1,291	65	0	0	0	4.00
5.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	0	0	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			329,107	16,456	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.06	OTHER A&G	0	0	0	40,251		1.00
2.00	17.01	INSERVICE EDUCATION	0	76,763	61,437	251,100		2.00
3.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	0	251,053	145,509	329,750		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	1,291	997	6,284,863		4.00
5.00	41.00	SUBPROVIDER - IRF	0	0	0	148,200		5.00
6.00	50.00	OPERATING ROOM	0	0	0	5,595,968		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	725,745		7.00
8.00	60.00	LABORATORY	0	0	0	623,510		8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	43,642		9.00
10.00	91.00	EMERGENCY	0	0	0	2,674,874		10.00
200.00			0	329,107	207,943	16,717,903		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet B
Part I
Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	MVBLE EQUIP		
		1.00	1.01	2.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	23,848,011	23,848,011			1.00
1.01 00101	NEW CAP BLDG & FIXT - OFFSITE	7,994,001	0	7,994,001		1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	21,714,847	0	11,608	0	21,726,455
5.01 00540	NONPATIENT TELEPHONES	0	0	0	0	0
5.02 00550	DATA PROCESSING	19,604,394	90,475	31,778	0	45,202
5.03 00560	PURCHASING RECEIVING AND STORES	89,873	242,258	0	0	14,757
5.04 00570	ADMITTING	8,452,265	12,617	54,675	0	1,164,110
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	226,943	0	0
5.06 00590	OTHER A&G	39,955,228	104,648	19,850	0	827,294
7.00 00700	OPERATION OF PLANT	0	300,508	45,215	0	0
8.00 00800	LAUNDRY & LINEN SERVICE	927,926	336,856	0	0	101,970
9.00 00900	HOUSEKEEPING	3,955,763	222,787	0	0	564,471
10.00 01000	DIETARY	2,368,429	500,028	0	0	231,243
11.00 01100	CAFETERIA	1,763,825	262,549	0	0	473,149
13.00 01300	NURSING ADMINISTRATION	323,913	53,389	0	0	63,582
14.00 01400	CENTRAL SERVICES & SUPPLY	6,376,000	229,696	0	0	119,739
15.00 01500	PHARMACY	45,099,562	269,567	0	0	947,058
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	137,008	0	0
17.00 01700	SOCIAL SERVICE	4,286,197	33,890	0	0	717,866
17.01 01701	INSERVICE EDUCATION	2,584,245	284,259	0	0	280,622
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	2,089,254	0	0	0	393,438
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	310,336	0	0	0	19,270
23.00 02300	PARAMED PRGM	282,847	28,975	77,776	0	55,965
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	31,959,351	2,986,238	0	0	4,885,850
31.00 03100	INTENSIVE CARE UNIT	6,874,646	670,490	0	0	859,549
40.00 04000	SUBPROVIDER - I PF	2,632,489	610,083	0	0	442,890
41.00 04100	SUBPROVIDER - I RF	1,883,335	488,776	0	0	322,297
43.00 04300	NURSERY	732,878	73,215	0	0	117,766
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	31,602,078	1,246,983	379,912	0	363,184
52.00 05200	DELIVERY ROOM & LABOR ROOM	924,377	227,102	0	0	124,758
54.00 05400	RADIOLOGY-DIAGNOSTIC	19,971,495	1,910,045	46,433	0	1,690,695
59.00 05900	CARDIAC CATHETERIZATION	8,745,292	370,829	0	0	435,978
60.00 06000	LABORATORY	15,741,874	794,555	0	0	1,046,242
65.00 06500	RESPIRATORY THERAPY	3,413,415	44,978	0	0	350,693
66.00 06600	PHYSICAL THERAPY	10,851,506	220,766	1,228,047	0	1,669,390
69.00 06900	ELECTROCARDIOLOGY	3,040,288	213,256	0	0	282,717
70.00 07000	ELECTROENCEPHALOGRAPHY	612,568	0	112,949	0	90,154
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	19,381,532	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00 07400	RENAL DIALYSIS	933,384	40,690	0	0	104
76.00 03950	ANCILLARY - OTHER	0	0	0	0	0
76.97 07697	CARDIAC REHABILITATION	611,059	223,524	0	0	100,545
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	11,080,848	845,541	0	0	1,699,533
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
93.00 04040	FAMILY PRACTICE	2,308,402	0	24,581	0	365,806
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	315,427	48,446	83,348	0	57,009
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
116.00 11600	HOSPICE	3,506,277	12,152	0	0	411,534
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	369,149,437	14,000,171	2,480,123	0	21,336,430
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	5,089,343	0	3,139,274	0	0
194.00 07950	RENTAL SPACE	5,928,712	0	566,778	0	0
194.01 07951	FOUNDATION	339,138	5,626	0	0	30,453
194.02 07952	RETAIL SERVICES	193,818	63,903	0	0	33,073
194.03 07953	REID CONTRACTED SERVICES	178,743	0	0	0	18,753
194.04 07954	REID PHYSICIAN ASSOC.	0	0	9,055	0	0
194.05 07955	CONNERSVILLE LOCATION	1,457,299	0	0	0	0
194.06 07956	VACANT SPACE	240,559	1,932,193	498,230	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet B
Part I
Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	MVBLE EQUIP		
			0	1.00	1.01	2.00	4.00	
194.07	07957	HOME OFFICE	0	7,640,918	1,300,541	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
194.09	07959	REID HEALTH PAVILION - RES	1,863,806	205,200	0	0	307,746	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	384,440,855	23,848,011	7,994,001	0	21,726,455	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet B
Part I
Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Description		NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINITTING	CASHIERING/AC COUNTS RECEIVABLE	
		5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES	0				5.01
5.02	00550	DATA PROCESSING	0	19,771,849			5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	26,919	373,807		5.03
5.04	00570	ADMINITTING	0	1,534,371	2,105	11,220,143	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	226,943	5.05
5.06	00590	OTHER A&G	0	1,090,211	1,851	0	5.06
7.00	00700	OPERATION OF PLANT	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,919	402	0	8.00
9.00	00900	HOUSEKEEPING	0	121,135	9,903	0	9.00
10.00	01000	DIETARY	0	713,348	4,417	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	188,432	28,222	0	14.00
15.00	01500	PHARMACY	0	888,320	41,725	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	471,079	454	0	17.00
17.01	01701	INSERVICE EDUCATION	0	821,023	353	0	17.01
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	349,944	39	0	22.00
23.00	02300	PARAMED PRGM	0	188,432	230	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,843,937	47,606	741,701	15,030
31.00	03100	INTENSIVE CARE UNIT	0	309,566	14,374	103,065	2,089
40.00	04000	SUBPROVIDER - IPF	0	228,810	2,678	49,074	994
41.00	04100	SUBPROVIDER - IRF	0	201,891	2,216	40,369	818
43.00	04300	NURSERY	0	0	2,342	12,773	259
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,830,478	46,373	1,857,820	37,648
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	174,972	4,820	78,386	1,588
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,005,447	49,212	1,949,809	39,084
59.00	05900	CARDIAC CATHETERIZATION	0	349,944	32,310	1,141,239	23,127
60.00	06000	LABORATORY	0	1,130,589	6,753	1,210,056	24,521
65.00	06500	RESPIRATORY THERAPY	0	188,432	17,154	266,086	5,392
66.00	06600	PHYSICAL THERAPY	0	1,897,774	2,614	249,856	5,063
69.00	06900	ELECTROCARDIOLOGY	0	511,457	1,252	297,204	6,023
70.00	07000	ELECTROENCEPHALOGRAPHY	0	269,188	1,996	68,527	1,389
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	408,842	8,285
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,474,693	29,884
74.00	07400	RENAL DIALYSIS	0	40,378	205	12,536	254
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	107,675	549	18,698	379
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	1,103,670	32,293	1,098,432	22,259
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	228,810	4,011	74,695	1,514
93.00	04040	FAMILY PRACTICE	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	148,053	4,039	4,545	92
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
116.00	11600	HOSPICE	0	403,782	7,410	61,737	1,251
118.00	11800	SUBTOTALS (SUM OF LINES 1 through 117)	0	19,394,986	369,908	11,220,143	226,943
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	78	0	0
194.00	07950	RENTAL SPACE	0	0	1,429	0	0
194.01	07951	FOUNDATION	0	53,838	612	0	0
194.02	07952	RETAIL SERVICES	0	13,459	87	0	0
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0
194.05	07955	CONNERSVILLE LOCATION	0	0	767	0	0
194.06	07956	VACANT SPACE	0	0	0	0	0
194.07	07957	HOME OFFICE	0	0	0	0	0
194.08	07958	CAMBRI DGE RHC	0	0	0	0	0
194.09	07959	REID HEALTH PAVILION - RES	0	309,566	926	0	0
200.00		Cross Foot Adjustments					200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet B
Part I
Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Description		NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINISTRATIVE	CASHIERING/AC COUNTS RECEIVABLE	
		5.01	5.02	5.03	5.04	5.05	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	19,771,849	373,807	11,220,143	226,943	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Prepared: 5/23/2023 11:46 am		
Cost Center Description			Subtotal	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
			5A.05	5.06	7.00	8.00	9.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE					1.01
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	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	OTHER A&G	41,999,082	41,999,082			5.06
7.00	00700	OPERATION OF PLANT	345,723	42,402	388,125		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,394,073	170,977	5,016	1,570,066	8.00
9.00	00900	HOUSEKEEPING	4,874,059	597,784	3,201	0	5,475,044
10.00	01000	DIETARY	3,817,465	468,197	7,446	0	175,846
11.00	01100	CAFETERIA	2,499,523	306,556	3,847	0	0
13.00	01300	NURSING ADMINISTRATION	440,884	54,073	795	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	6,942,089	851,419	3,420	0	63,071
15.00	01500	PHARMACY	47,246,232	5,794,529	3,920	0	69,754
16.00	01600	MEDICAL RECORDS & LIBRARY	137,008	16,803	0	0	0
17.00	01700	SOCIAL SERVICE	5,509,486	675,716	178	0	22,555
17.01	01701	INSERVICE EDUCATION	3,970,502	486,966	3,791	0	68,083
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,482,692	304,492	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	679,589	83,349	0	0	0
23.00	02300	PARAMED PRGM	634,225	77,785	1,141	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	42,479,713	5,209,967	44,017	536,424	2,552,487
31.00	03100	INTENSIVE CARE UNIT	8,833,779	1,083,428	9,984	113,105	390,538
40.00	04000	SUBPROVIDER - IPF	3,967,018	486,539	9,085	115,449	203,414
41.00	04100	SUBPROVIDER - IRF	2,939,702	360,543	7,278	49,983	176,264
43.00	04300	NURSERY	939,233	115,193	1,090	0	17,543
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	37,364,476	4,582,604	16,520	125,028	454,444
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,536,003	188,385	3,382	74,629	73,931
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,662,220	3,392,661	21,910	153,958	187,124
59.00	05900	CARDIAC CATHETERIZATION	11,098,719	1,361,213	1,868	73,234	58,476
60.00	06000	LABORATORY	19,954,590	2,447,351	8,212	968	138,254
65.00	06500	RESPIRATORY THERAPY	4,286,150	525,679	486	0	25,897
66.00	06600	PHYSICAL THERAPY	16,125,016	1,977,669	19,609	13,326	39,680
69.00	06900	ELECTROCARDIOLOGY	4,352,197	533,780	227	0	58,476
70.00	07000	ELECTROENCEPHALOGRAPHY	1,156,771	141,873	2,196	6,366	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,798,659	2,428,226	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,504,577	184,530	0	0	0
74.00	07400	RENAL DIALYSIS	1,027,551	126,025	606	0	67,665
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	1,062,429	130,303	1,489	0	16,707
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	15,882,576	1,947,934	12,591	212,071	372,995
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
93.00	04040	FAMILY PRACTICE	3,007,819	368,897	0	46,682	89,803
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	660,959	81,064	1,526	0	4,177
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
116.00	11600	HOSPICE	4,404,143	540,151	0	0	79,778
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	353,016,932	38,145,063	194,831	1,521,223	5,406,962
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,228,695	1,009,217	43,989	42,420	58,476
194.00	07950	RENTAL SPACE	6,496,919	796,821	9,320	0	0
194.01	07951	FOUNDATION	429,667	52,697	84	0	3,341
194.02	07952	RETAIL SERVICES	304,340	37,326	278	0	6,265
194.03	07953	REID CONTRACTED SERVICES	197,496	24,222	0	0	0
194.04	07954	REID PHYSICIAN ASSOC.	9,055	1,111	0	0	0
194.05	07955	CONNERSVILLE LOCATION	1,458,066	178,826	0	0	0
194.06	07956	VACANT SPACE	2,670,982	327,585	37,833	0	0
194.07	07957	HOME OFFICE	8,941,459	1,096,634	98,734	0	0
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0
194.09	07959	REID HEALTH PAVILION - RES	2,687,244	329,580	3,056	6,423	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0048			Period: From 01/01/2022 To 12/31/2022		Worksheet B Part I Date/Time Prepared: 5/23/2023 11:46 am	
Cost Center Description		Subtotal	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5A.05	5.06	7.00	8.00	9.00		
202.00	TOTAL (sum lines 118 through 201)	384,440,855	41,999,082	388,125	1,570,066	5,475,044	202.00	

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0048		Period: From 01/01/2022 To 12/31/2022		Worksheet B Part I Date/Time Prepared: 5/23/2023 11:46 am	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
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	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
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	4,468,954					10.00
11.00	01100	CAFETERIA	0	2,809,926				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,208	497,960			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	34,181	0	7,894,180		14.00
15.00	01500	PHARMACY	0	134,802	0	7,892	53,257,129	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	103,789	0	0	0	17.00
17.01	01701	INSERVICE EDUCATION	0	45,045	0	0	833	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	41,899	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	4,849	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	7,144	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,251,908	737,035	219,802	23,731	1,159	30.00
31.00	03100	INTENSIVE CARE UNIT	453,522	113,183	33,754	23,895	1,206	31.00
40.00	04000	SUBPROVIDER - IPF	416,967	69,494	20,725	168	0	40.00
41.00	04100	SUBPROVIDER - IRF	346,557	47,040	14,028	830	11	41.00
43.00	04300	NURSERY	0	14,253	4,250	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	62,470	18,630	3,817,122	204,068	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	16,868	5,030	13,875	4,198	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	252,369	75,262	59,422	951,397	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	56,465	16,839	3,375,755	453	59.00
60.00	06000	LABORATORY	0	210,212	0	393,621	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	49,224	14,680	6,069	94	65.00
66.00	06600	PHYSICAL THERAPY	0	253,909	0	160	76	66.00
69.00	06900	ELECTROCARDIOLOGY	0	45,236	0	72,130	312,725	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	17,424	0	14	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	51,458,281	73.00
74.00	07400	RENAL DIALYSIS	0	10	3	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	19,137	5,707	147	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	232,210	69,250	19,801	144,441	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	75,955	0	0	25,537	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	16,202	0	79,477	856	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	61,099	0	71	132,778	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,468,954	2,723,712	497,960	7,894,180	53,238,113	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	6,829	0	0	0	194.01
194.02	07952	RETAIL SERVICES	0	8,561	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	5,249	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRI DGE RHC	0	0	0	0	0	194.08
194.09	07959	REID HEALTH PAVILION - RES	0	65,575	0	0	19,016	194.09
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet B
Part I
Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	4,468,954	2,809,926	497,960	7,894,180	53,257,129	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Prepared: 5/23/2023 11:46 am
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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INSERVICE EDUCATION	INTERNS & RESIDENTS		
				SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
				16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	NEW CAP BLDG & FIXT - OFFSITE					1.01
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 00550	DATA PROCESSING					5.02
5.03 00560	PURCHASING RECEIVING AND STORES					5.03
5.04 00570	ADMITTING					5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06 00590	OTHER A&G					5.06
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	153,811				16.00
17.00 01700	SOCIAL SERVICE	0	6,311,724			17.00
17.01 01701	INSERVICE EDUCATION	0	0	4,575,220		17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	2,829,083	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
22.00 02300	PARAMED ED PRGM	0	0	13,288	767,787	22.00
23.00 02300	PARAMED ED PRGM	0	0	13,288	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	10,199	4,174,442	1,337,699	2,082,303	565,117
31.00 03100	INTENSIVE CARE UNIT	1,417	492,557	196,479	81,625	22,152
40.00 04000	SUBPROVIDER - I PF	675	0	121,705	0	0
41.00 04100	SUBPROVIDER - IRF	555	0	82,051	0	0
43.00 04300	NURSERY	176	0	24,784	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	25,547	0	302,259	142,409	38,649
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,078	0	29,635	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	26,333	0	466,254	43,417	11,783
59.00 05900	CARDIAC CATHETERIZATION	15,693	0	97,765	0	0
60.00 06000	LABORATORY	16,640	0	378,614	0	0
65.00 06500	RESPIRATORY THERAPY	3,659	0	94,917	0	0
66.00 06600	PHYSICAL THERAPY	3,436	0	457,817	0	0
69.00 06900	ELECTROCARDIOLOGY	4,087	0	86,797	72,941	19,796
70.00 07000	ELECTROENCEPHALOGRAPHY	942	0	29,952	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	5,622	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	20,279	0	0	0	0
74.00 07400	RENAL DIALYSIS	172	0	0	0	0
76.00 03950	ANCILLARY - OTHER	0	0	0	0	0
76.97 07697	CARDIAC REHABILITATION	257	0	33,010	0	0
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	15,105	1,644,725	446,322	175,407	47,604
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
93.00 04040	FAMILY PRACTICE	1,027	0	131,935	0	0
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	63	0	27,948	0	0
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
116.00 11600	HOSPICE	849	0	74,985		
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	153,811	6,311,724	4,434,216	2,598,102	705,101
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	230,981	62,686
194.00 07950	RENTAL SPACE	0	0	0	0	0
194.01 07951	FOUNDATION	0	0	11,706	0	0
194.02 07952	RETAIL SERVICES	0	0	14,765	0	0
194.03 07953	REID CONTRACTED SERVICES	0	0	0	0	0
194.04 07954	REID PHYSICIAN ASSOC.	0	0	0	0	0
194.05 07955	CONNERSVILLE LOCATION	0	0	0	0	0
194.06 07956	VACANT SPACE	0	0	0	0	0
194.07 07957	HOME OFFICE	0	0	0	0	0
194.08 07958	CAMBRI DGE RHC	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet B
Part I
Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INSERVICE EDUCATION	INTERNS & RESIDENTS		
				SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
				16.00	17.00	
194.09 07959 REID HEALTH PAVILION - RES	0	0	114,533	0	0	194.09
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)	153,811	6,311,724	4,575,220	2,829,083	767,787	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet B
Part I
Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Description		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
1.01	00101					1.01
2.00	00200					2.00
4.00	00400					4.00
5.01	00540					5.01
5.02	00550					5.02
5.03	00560					5.03
5.04	00570					5.04
5.05	00580					5.05
5.06	00590					5.06
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
14.00	01400					14.00
15.00	01500					15.00
16.00	01600					16.00
17.00	01700					17.00
17.01	01701					17.01
21.00	02100					21.00
22.00	02200					22.00
23.00	02300	733,583				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	0	63,226,003	-2,647,420	60,578,583	30.00
31.00	03100	0	11,850,624	-103,777	11,746,847	31.00
40.00	04000	0	5,411,239	0	5,411,239	40.00
41.00	04100	0	4,024,842	0	4,024,842	41.00
43.00	04300	0	1,116,522	0	1,116,522	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	0	47,154,226	-181,058	46,973,168	50.00
52.00	05200	0	1,947,014	0	1,947,014	52.00
54.00	05400	733,583	34,037,693	-55,200	33,982,493	54.00
59.00	05900	0	16,156,480	0	16,156,480	59.00
60.00	06000	0	23,548,462	0	23,548,462	60.00
65.00	06500	0	5,006,855	0	5,006,855	65.00
66.00	06600	0	18,890,698	0	18,890,698	66.00
69.00	06900	0	5,558,392	-92,737	5,465,655	69.00
70.00	07000	0	1,355,538	0	1,355,538	70.00
71.00	07100	0	0	0	0	71.00
72.00	07200	0	22,232,507	0	22,232,507	72.00
73.00	07300	0	53,167,667	0	53,167,667	73.00
74.00	07400	0	1,222,032	0	1,222,032	74.00
76.00	03950	0	0	0	0	76.00
76.97	07697	0	1,269,186	0	1,269,186	76.97
77.00	07700	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	0	21,223,032	-223,011	21,000,021	91.00
92.00	09200	0	0	0	0	92.00
93.00	04040	0	3,747,655	0	3,747,655	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	0	872,272	0	872,272	96.00
102.00	10200	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	0	0	0	0	113.00
116.00	11600	0	5,293,854	0	5,293,854	116.00
118.00		733,583	348,312,793	-3,303,203	345,009,590	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	9,676,464	-293,667	9,382,797	192.00
194.00	07950	0	7,303,060	0	7,303,060	194.00
194.01	07951	0	504,324	0	504,324	194.01
194.02	07952	0	371,535	0	371,535	194.02
194.03	07953	0	226,967	0	226,967	194.03
194.04	07954	0	10,166	0	10,166	194.04
194.05	07955	0	1,636,892	0	1,636,892	194.05
194.06	07956	0	3,036,400	0	3,036,400	194.06
194.07	07957	0	10,136,827	0	10,136,827	194.07
194.08	07958	0	0	0	0	194.08

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet B
Part I
Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Description		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23.00	24.00	25.00	26.00		
194.09	07959 REID HEALTH PAVILION - RES	0	3,225,427	0	3,225,427		194.09
200.00	Cross Foot Adjustments	0	0	0	0		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	733,583	384,440,855	-3,596,870	380,843,985		202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prepared: 5/23/2023 11:46 am
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Cost Center Description		CAPITAL RELATED COSTS				Subtotal	
		Directly Assigned New Capital Related Costs	BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	MVBLE EQUIP		
		0	1.00	1.01	2.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	381	0	11,608	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	5.01
5.02	00550	DATA PROCESSING	18,900	90,475	31,778	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	242,258	0	0	5.03
5.04	00570	ADMITTING	99,298	12,617	54,675	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	4,610	0	226,943	0	5.05
5.06	00590	OTHER A&G	81,792	104,648	19,850	0	5.06
7.00	00700	OPERATION OF PLANT	0	300,508	45,215	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	59,503	336,856	0	0	8.00
9.00	00900	HOUSEKEEPING	87,090	222,787	0	0	9.00
10.00	01000	DIETARY	125,674	500,028	0	0	10.00
11.00	01100	CAFETERIA	0	262,549	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	53,389	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	189,729	229,696	0	0	14.00
15.00	01500	PHARMACY	973,897	269,567	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	137,008	0	16.00
17.00	01700	SOCIAL SERVICE	2,255	33,890	0	0	17.00
17.01	01701	INSERVICE EDUCATION	18,038	284,259	0	0	17.01
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	13,784	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	3,432	28,975	77,776	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	604,818	2,986,238	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	436,069	670,490	0	0	31.00
40.00	04000	SUBPROVIDER - I PF	31,755	610,083	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	24,465	488,776	0	0	41.00
43.00	04300	NURSERY	12,797	73,215	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,795,324	1,246,983	379,912	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,839	227,102	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,272,696	1,910,045	46,433	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	927,946	370,829	0	0	59.00
60.00	06000	LABORATORY	806,358	794,555	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	105,845	44,978	0	0	65.00
66.00	06600	PHYSICAL THERAPY	94,224	220,766	1,228,047	0	66.00
69.00	06900	ELECTROCARDIOLOGY	235,642	213,256	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	33,176	0	112,949	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	10,366	40,690	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	5,457	223,524	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	364,887	845,541	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
93.00	04040	FAMILY PRACTICE	37,563	0	24,581	0	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	2,481	48,446	83,348	0	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	6,353	12,152	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,518,444	14,000,171	2,480,123	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	116,699	0	3,139,274	0	192.00
194.00	07950	RENTAL SPACE	356,164	0	566,778	0	194.00
194.01	07951	FOUNDATION	3,320	5,626	0	0	194.01
194.02	07952	RETAIL SERVICES	143	63,903	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	9,055	0	194.04
194.05	07955	CONNERSVILLE LOCATION	77,252	0	0	0	194.05
194.06	07956	VACANT SPACE	10,874	1,932,193	498,230	0	194.06
194.07	07957	HOME OFFICE	0	7,640,918	1,300,541	0	194.07

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet B
Part II
Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	MVBLE EQUIP		
		1.00	1.01	2.00		
	0				2A	
194.08 07958 CAMBRIDGE RHC	0	0	0	0	0	194.08
194.09 07959 REID HEALTH PAVILION - RES	48,127	205,200	0	0	253,327	194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	11,131,023	23,848,011	7,994,001	0	42,973,035	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prepared: 5/23/2023 11:46 am
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Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINISTRATIVE	
		4.00	5.01	5.02	5.03	5.04	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11,989				4.00
5.01	00540	NONPATIENT TELEPHONES	0	0			5.01
5.02	00550	DATA PROCESSING	25	141,178			5.02
5.03	00560	PURCHASING RECEIVING AND STORES	8	192	242,458		5.03
5.04	00570	ADMINISTRATIVE	640	10,956	1,365	179,551	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	5.05
5.06	00590	OTHER A&G	455	7,784	1,201	0	5.06
7.00	00700	OPERATION OF PLANT	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	56	192	261	0	8.00
9.00	00900	HOUSEKEEPING	311	865	6,423	0	9.00
10.00	01000	DIETARY	127	5,094	2,865	0	10.00
11.00	01100	CAFETERIA	260	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	35	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66	1,345	18,306	0	14.00
15.00	01500	PHARMACY	521	6,343	27,063	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	395	3,364	295	0	17.00
17.01	01701	INSERVICE EDUCATION	154	5,862	229	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	216	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	11	2,499	26	0	22.00
23.00	02300	PARAMED ED PRGM	31	1,345	149	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,725	13,166	30,878	11,886	30.00
31.00	03100	INTENSIVE CARE UNIT	473	2,210	9,323	1,652	31.00
40.00	04000	SUBPROVIDER - IPF	244	1,634	1,737	786	40.00
41.00	04100	SUBPROVIDER - IRF	177	1,442	1,437	647	41.00
43.00	04300	NURSERY	65	0	1,519	205	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	200	13,070	30,078	29,773	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	69	1,249	3,126	1,256	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	930	14,322	31,918	30,988	54.00
59.00	05900	CARDIAC CATHETERIZATION	240	2,499	20,957	18,289	59.00
60.00	06000	LABORATORY	576	8,073	4,380	19,392	60.00
65.00	06500	RESPIRATORY THERAPY	193	1,345	11,127	4,264	65.00
66.00	06600	PHYSICAL THERAPY	918	13,551	1,695	4,004	66.00
69.00	06900	ELECTROCARDIOLOGY	156	3,652	812	4,763	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	50	1,922	1,295	1,098	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,552	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	23,633	73.00
74.00	07400	RENAL DIALYSIS	0	288	133	201	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	55	769	356	300	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	935	7,881	20,946	17,603	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00	04040	FAMILY PRACTICE	201	1,634	2,602	1,197	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	31	1,057	2,620	73	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	226	2,883	4,806	989	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,775	138,488	239,928	179,551	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	51	0	192.00
194.00	07950	RENTAL SPACE	0	0	927	0	194.00
194.01	07951	FOUNDATION	17	384	397	0	194.01
194.02	07952	RETAIL SERVICES	18	96	57	0	194.02
194.03	07953	REID CONTRACTED SERVICES	10	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	497	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	194.07
194.08	07958	CAMBRI DGE RHC	0	0	0	0	194.08
194.09	07959	REID HEALTH PAVILION - RES	169	2,210	601	0	194.09
200.00		Cross Foot Adjustments					200.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0048			Period: From 01/01/2022 To 12/31/2022		Worksheet B Part II Date/Time Prepared: 5/23/2023 11:46 am	
Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT 4.00	NONPATIENT TELEPHONES 5.01	DATA PROCESSING 5.02	PURCHASING RECEIVING AND STORES 5.03	ADMINISTRATIVE 5.04		
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	11,989	0	141,178	242,458	179,551		202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0048		Period: From 01/01/2022 To 12/31/2022		Worksheet B Part II Date/Time Prepared: 5/23/2023 11:46 am	
Cost Center Description			CASHIERING/AC COUNTS RECEIVABLE	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.05	5.06	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
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	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	231,553					5.05
5.06	00590	OTHER A&G	0	215,730				5.06
7.00	00700	OPERATION OF PLANT	0	218	345,941			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	878	4,471	402,217		8.00
9.00	00900	HOUSEKEEPING	0	3,071	2,853	0	323,400	9.00
10.00	01000	DIETARY	0	2,405	6,636	0	10,387	10.00
11.00	01100	CAFETERIA	0	1,575	3,429	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	278	709	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,374	3,049	0	3,725	14.00
15.00	01500	PHARMACY	0	29,756	3,494	0	4,120	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	86	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,471	159	0	1,332	17.00
17.01	01701	INSERVICE EDUCATION	0	2,501	3,379	0	4,022	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	1,564	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	428	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	400	1,017	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,337	26,762	39,233	137,421	150,772	30.00
31.00	03100	INTENSIVE CARE UNIT	2,131	5,565	8,899	28,975	23,068	31.00
40.00	04000	SUBPROVIDER - IPF	1,015	2,499	8,097	29,575	12,015	40.00
41.00	04100	SUBPROVIDER - IRF	835	1,852	6,487	12,805	10,412	41.00
43.00	04300	NURSERY	264	592	972	0	1,036	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	38,416	23,540	14,724	32,029	26,843	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,621	968	3,014	19,118	4,367	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,857	17,427	19,529	39,441	11,053	54.00
59.00	05900	CARDIAC CATHETERIZATION	23,599	6,992	1,665	18,761	3,454	59.00
60.00	06000	LABORATORY	25,022	12,571	7,319	248	8,166	60.00
65.00	06500	RESPIRATORY THERAPY	5,502	2,700	433	0	1,530	65.00
66.00	06600	PHYSICAL THERAPY	5,167	10,159	17,477	3,414	2,344	66.00
69.00	06900	ELECTROCARDIOLOGY	6,146	2,742	202	0	3,454	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,417	729	1,957	1,631	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	8,454	12,473	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,494	948	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	259	647	540	0	3,997	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	387	669	1,327	0	987	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	22,714	10,006	11,222	54,328	22,032	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	FAMILY PRACTICE	1,545	1,895	0	11,959	5,304	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	94	416	1,360	0	247	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,277	2,775	0	0	4,712	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	231,553	195,932	173,653	389,705	319,379	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,184	39,208	10,867	3,454	192.00
194.00	07950	RENTAL SPACE	0	4,093	8,307	0	0	194.00
194.01	07951	FOUNDATION	0	271	75	0	197	194.01
194.02	07952	RETAIL SERVICES	0	192	248	0	370	194.02
194.03	07953	REID CONTRACTED SERVICES	0	124	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	6	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	919	0	0	0	194.05
194.06	07956	VACANT SPACE	0	1,683	33,721	0	0	194.06
194.07	07957	HOME OFFICE	0	5,633	88,006	0	0	194.07
194.08	07958	CAMBRI DGE RHC	0	0	0	0	0	194.08
194.09	07959	REID HEALTH PAVILION - RES	0	1,693	2,723	1,645	0	194.09
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0048			Period: From 01/01/2022 To 12/31/2022		Worksheet B Part II Date/Time Prepared: 5/23/2023 11:46 am	
Cost Center Description		CASHIERING/AC COUNTS RECEIVABLE	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.05	5.06	7.00	8.00	9.00		
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	231,553	215,730	345,941	402,217	323,400		202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0048		Period: From 01/01/2022 To 12/31/2022		Worksheet B Part II Date/Time Prepared: 5/23/2023 11:46 am	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
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	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMINISTRATIVE						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
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	653,216					10.00
11.00	01100	CAFETERIA	0	267,813				11.00
13.00	01300	NURSING ADMINISTRATION	0	210	54,621			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,258	0	453,548		14.00
15.00	01500	PHARMACY	0	12,848	0	453	1,328,062	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	9,892	0	0	0	17.00
17.01	01701	INSERVICE EDUCATION	0	4,293	0	0	21	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	3,993	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	462	0	0	0	22.00
23.00	02300	PARAMED PRGM	0	681	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	475,324	70,249	24,111	1,363	29	30.00
31.00	03100	INTENSIVE CARE UNIT	66,290	10,787	3,702	1,373	30	31.00
40.00	04000	SUBPROVIDER - IPF	60,947	6,623	2,273	10	0	40.00
41.00	04100	SUBPROVIDER - IRF	50,655	4,483	1,539	48	0	41.00
43.00	04300	NURSERY	0	1,358	466	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	5,954	2,044	219,312	5,089	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,608	552	797	105	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,053	8,255	3,414	23,725	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	5,382	1,847	193,945	11	59.00
60.00	06000	LABORATORY	0	20,035	0	22,614	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,692	1,610	349	2	65.00
66.00	06600	PHYSICAL THERAPY	0	24,200	0	9	2	66.00
69.00	06900	ELECTROCARDIOLOGY	0	4,311	0	4,144	7,798	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,661	0	1	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	1,283,205	73.00
74.00	07400	RENAL DIALYSIS	0	1	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,824	626	8	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	22,132	7,596	1,138	3,602	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	7,239	0	0	637	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	1,544	0	4,566	21	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	5,823	0	4	3,311	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	653,216	259,596	54,621	453,548	1,327,588	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	651	0	0	0	194.01
194.02	07952	RETAIL SERVICES	0	816	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	500	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRI DGE RHC	0	0	0	0	0	194.08
194.09	07959	REID HEALTH PAVILION - RES	0	6,250	0	0	474	194.09
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet B
Part II
Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Description		DI ETARY	CAFETERIA	NURSING ADM INI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	653,216	267,813	54,621	453,548	1,328,062	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prepared: 5/23/2023 11:46 am
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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INSERVICE EDUCATION	INTERNS & RESIDENTS		
				SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
				16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	NEW CAP BLDG & FIXT - OFFSITE					1.01
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 00550	DATA PROCESSING					5.02
5.03 00560	PURCHASING RECEIVING AND STORES					5.03
5.04 00570	ADMINISTRATIVE					5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06 00590	OTHER A&G					5.06
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	137,094				16.00
17.00 01700	SOCIAL SERVICE	0	55,053			17.00
17.01 01701	INSERVICE EDUCATION	0	0	322,758		17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	5,773	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		22.00
23.00 02300	PARAMED ED PRGM	0	0	937		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	9,049	36,411	94,365		30.00
31.00 03100	INTENSIVE CARE UNIT	1,257	4,296	13,861		31.00
40.00 04000	SUBPROVIDER - I PF	599	0	8,586		40.00
41.00 04100	SUBPROVIDER - IRF	493	0	5,788		41.00
43.00 04300	NURSERY	156	0	1,748		43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	22,666	0	21,323		50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	956	0	2,091		52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	23,996	0	32,892		54.00
59.00 05900	CARDIAC CATHETERIZATION	13,923	0	6,897		59.00
60.00 06000	LABORATORY	14,763	0	26,709		60.00
65.00 06500	RESPIRATORY THERAPY	3,246	0	6,696		65.00
66.00 06600	PHYSICAL THERAPY	3,048	0	32,297		66.00
69.00 06900	ELECTROCARDIOLOGY	3,626	0	6,123		69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	836	0	2,113		70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	4,988	0	0		72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	17,991	0	0		73.00
74.00 07400	RENAL DIALYSIS	153	0	0		74.00
76.00 03950	ANCILLARY - OTHER	0	0	0		76.00
76.97 07697	CARDIAC REHABILITATION	228	0	2,329		76.97
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0		77.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	13,401	14,346	31,486		91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00 04040	FAMILY PRACTICE	911	0	9,307		93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	55	0	1,972		96.00
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	753	0	5,290		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	137,094	55,053	312,810	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00 07950	RENTAL SPACE	0	0	0		194.00
194.01 07951	FOUNDATION	0	0	826		194.01
194.02 07952	RETAIL SERVICES	0	0	1,042		194.02
194.03 07953	REID CONTRACTED SERVICES	0	0	0		194.03
194.04 07954	REID PHYSICIAN ASSOC.	0	0	0		194.04
194.05 07955	CONNERSVILLE LOCATION	0	0	0		194.05
194.06 07956	VACANT SPACE	0	0	0		194.06
194.07 07957	HOME OFFICE	0	0	0		194.07
194.08 07958	CAMBRI DGE RHC	0	0	0		194.08

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet B
Part II
Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INSERVICE EDUCATION	INTERNS & RESIDENTS		
				SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
				16.00	17.00	
194.09 07959 REID HEALTH PAVILION - RES	0	0	8,080			194.09
200.00 Cross Foot Adjustments				5,773	17,210	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	137,094	55,053	322,758	5,773	17,210	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prepared: 5/23/2023 11:46 am	
Cost Center	Description	PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE				1.01
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	00550	DATA PROCESSING				5.02
5.03	00560	PURCHASING RECEIVING AND STORES				5.03
5.04	00570	ADMITTING				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.05
5.06	00590	OTHER A&G				5.06
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
17.01	01701	INSERVICE EDUCATION				17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300	PARAMED PRGM	114,743			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,730,137	0	4,730,137	30.00
31.00	03100	INTENSIVE CARE UNIT	1,290,451	0	1,290,451	31.00
40.00	04000	SUBPROVIDER - I PF	778,478	0	778,478	40.00
41.00	04100	SUBPROVIDER - IRF	612,341	0	612,341	41.00
43.00	04300	NURSERY	94,393	0	94,393	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,907,280	0	3,907,280	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	299,838	0	299,838	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,550,974	0	5,550,974	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,617,236	0	1,617,236	59.00
60.00	06000	LABORATORY	1,770,781	0	1,770,781	60.00
65.00	06500	RESPIRATORY THERAPY	194,512	0	194,512	65.00
66.00	06600	PHYSICAL THERAPY	1,661,322	0	1,661,322	66.00
69.00	06900	ELECTROCARDIOLOGY	496,827	0	496,827	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	160,835	0	160,835	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,467	0	32,467	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,356,271	0	1,356,271	73.00
74.00	07400	RENAL DIALYSIS	57,275	0	57,275	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	238,846	0	238,846	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,471,796	0	1,471,796	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
93.00	04040	FAMILY PRACTICE	106,575	0	106,575	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	148,331	0	148,331	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	51,354	0	51,354	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	26,628,320	26,628,320	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,314,737	0	3,314,737	192.00
194.00	07950	RENTAL SPACE	936,269	0	936,269	194.00
194.01	07951	FOUNDATION	11,764	0	11,764	194.01
194.02	07952	RETAIL SERVICES	66,885	0	66,885	194.02
194.03	07953	REID CONTRACTED SERVICES	634	0	634	194.03
194.04	07954	REID PHYSICIAN ASSOC.	9,061	0	9,061	194.04
194.05	07955	CONNERSVILLE LOCATION	78,668	0	78,668	194.05
194.06	07956	VACANT SPACE	2,476,701	0	2,476,701	194.06
194.07	07957	HOME OFFICE	9,035,098	0	9,035,098	194.07
194.08	07958	CAMBRI DGE RHC	0	0	0	194.08

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prepared: 5/23/2023 11:46 am		
Cost Center Description		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.00	24.00	25.00	26.00	
194.09	07959 REID HEALTH PAVILION - RES		277,172	0	277,172	194.09
200.00	Cross Foot Adjustments	114,743	137,726	0	137,726	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	114,743	42,973,035	0	42,973,035	202.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet B-1 Date/Time Prepared: 5/23/2023 11:46 am
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Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	
		BLDG & FIXT (SQUARE FEET)	NEW CAP BLDG & FIXT - OFFSITE (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)			
		1.00	1.01	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	873,266				1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE	0	275,457			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	400	0	110,683,096	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	5.01
5.02	00550	DATA PROCESSING	3,313	1,095	0	230,277	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	8,871	0	0	75,178	5.03
5.04	00570	ADMINISTRATIVE	462	1,884	0	5,930,442	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	7,820	0	0	5.05
5.06	00590	OTHER A&G	3,832	684	0	4,214,566	5.06
7.00	00700	OPERATION OF PLANT	11,004	1,558	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,335	0	0	519,475	8.00
9.00	00900	HOUSEKEEPING	8,158	0	0	2,875,641	9.00
10.00	01000	DIETARY	18,310	0	0	1,178,046	10.00
11.00	01100	CAFETERIA	9,614	0	0	2,410,409	11.00
13.00	01300	NURSING ADMINISTRATION	1,955	0	0	323,913	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,411	0	0	609,997	14.00
15.00	01500	PHARMACY	9,871	0	0	4,824,693	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,721	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,241	0	0	3,657,098	17.00
17.01	01701	INSERVICE EDUCATION	10,409	0	0	1,429,603	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	2,004,328	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	98,170	22.00
23.00	02300	PARAMED PRGM	1,061	2,680	0	285,110	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	109,350	0	0	24,890,328	30.00
31.00	03100	INTENSIVE CARE UNIT	24,552	0	0	4,378,887	31.00
40.00	04000	SUBPROVIDER - I PF	22,340	0	0	2,256,259	40.00
41.00	04100	SUBPROVIDER - I RF	17,898	0	0	1,641,909	41.00
43.00	04300	NURSERY	2,681	0	0	599,946	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	45,662	13,091	0	1,850,204	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,316	0	0	635,566	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	69,942	1,600	0	8,613,073	54.00
59.00	05900	CARDIAC CATHETERIZATION	13,579	0	0	2,221,045	59.00
60.00	06000	LABORATORY	29,095	0	0	5,329,975	60.00
65.00	06500	RESPIRATORY THERAPY	1,647	0	0	1,786,568	65.00
66.00	06600	PHYSICAL THERAPY	8,084	42,316	0	8,504,540	66.00
69.00	06900	ELECTROCARDIOLOGY	7,809	0	0	1,440,272	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,892	0	459,280	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,490	0	0	532	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	8,185	0	0	512,214	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	30,962	0	0	8,658,101	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00	04040	FAMILY PRACTICE	0	847	0	1,863,561	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,774	2,872	0	290,425	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	445	0	0	2,096,519	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	512,658	85,460	0	108,696,150	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	108,173	0	0	192.00
194.00	07950	RENTAL SPACE	0	19,530	0	0	194.00
194.01	07951	FOUNDATION	206	0	0	155,142	194.01
194.02	07952	RETAIL SERVICES	2,340	0	0	168,485	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	95,536	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	312	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	194.05
194.06	07956	VACANT SPACE	70,753	17,168	0	0	194.06

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet B-1

Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	
	BLDG & FIXT (SQUARE FEET)	NEW CAP BLDG & FIXT - OFFSITE (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)			
	1.00	1.01	2.00			
194.0707957 HOME OFFICE	279,795	44,814	0	0	0	194.07
194.0807958 CAMBRIDGE RHC	0	0	0	0	0	194.08
194.0907959 REID HEALTH PAVILION - RES	7,514	0	0	1,567,783	0	194.09
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)	23,848,011	7,994,001	0	21,726,455	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	27.308988	29.020867	0.000000	0.196294	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)				11,989	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)				0.000108	0.000000	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet B-1

Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Description		DATA PROCESSING (TERMINALS)	PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	ADMINING (TOTAL REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (TOTAL REVENUE)	Reconciliation		
		5.02	5.03	5.04	5.05	5A.06		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
1.01	00101						1.01	
2.00	00200						2.00	
4.00	00400						4.00	
5.01	00540						5.01	
5.02	00550	1,469					5.02	
5.03	00560	2	9,998,360				5.03	
5.04	00570	114	56,305	1,160,060,725			5.04	
5.05	00580	0	0	0	1,160,060,725		5.05	
5.06	00590	81	49,518	0	0	-41,999,082	5.06	
7.00	00700	0	0	0	0	0	7.00	
8.00	00800	2	10,751	0	0	0	8.00	
9.00	00900	9	264,870	0	0	0	9.00	
10.00	01000	53	118,153	0	0	0	10.00	
11.00	01100	0	0	0	0	0	11.00	
13.00	01300	0	0	0	0	0	13.00	
14.00	01400	14	754,871	0	0	0	14.00	
15.00	01500	66	1,116,020	0	0	0	15.00	
16.00	01600	0	0	0	0	0	16.00	
17.00	01700	35	12,150	0	0	0	17.00	
17.01	01701	61	9,451	0	0	0	17.01	
21.00	02100	0	0	0	0	0	21.00	
22.00	02200	26	1,055	0	0	0	22.00	
23.00	02300	14	6,150	0	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	137	1,273,321	76,685,350	76,685,350	0	30.00	
31.00	03100	23	384,454	10,656,052	10,656,052	0	31.00	
40.00	04000	17	71,634	5,073,786	5,073,786	0	40.00	
41.00	04100	15	59,271	4,173,816	4,173,816	0	41.00	
43.00	04300	0	62,648	1,320,590	1,320,590	0	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	136	1,240,339	192,082,267	192,082,267	0	50.00	
52.00	05200	13	128,926	8,104,428	8,104,428	0	52.00	
54.00	05400	149	1,316,288	201,589,585	201,589,585	0	54.00	
59.00	05900	26	864,206	117,994,072	117,994,072	0	59.00	
60.00	06000	84	180,614	125,109,226	125,109,226	0	60.00	
65.00	06500	14	458,826	27,510,977	27,510,977	0	65.00	
66.00	06600	141	69,915	25,832,875	25,832,875	0	66.00	
69.00	06900	38	33,481	30,728,297	30,728,297	0	69.00	
70.00	07000	20	53,386	7,085,048	7,085,048	0	70.00	
71.00	07100	0	0	0	0	0	71.00	
72.00	07200	0	0	42,270,688	42,270,688	0	72.00	
73.00	07300	0	0	152,470,298	152,470,298	0	73.00	
74.00	07400	3	5,494	1,296,107	1,296,107	0	74.00	
76.00	03950	0	0	0	0	0	76.00	
76.97	07697	8	14,688	1,933,167	1,933,167	0	76.97	
77.00	07700	0	0	0	0	0	77.00	
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	82	863,762	113,568,281	113,568,281	0	91.00	
92.00	09200						92.00	
93.00	04040	17	107,289	7,722,846	7,722,846	0	93.00	
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	11	108,031	469,944	469,944	0	96.00	
102.00	10200	0	0	0	0	0	102.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300						113.00	
116.00	11600	30	198,194	6,383,025	6,383,025	0	116.00	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		1,441	9,894,061	1,160,060,725	1,160,060,725	-41,999,082	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	0	0	0	0	0	190.00	
192.00	19200	0	2,089	0	0	0	192.00	
194.00	07950	0	38,230	0	0	0	194.00	
194.01	07951	4	16,367	0	0	0	194.01	
194.02	07952	1	2,330	0	0	0	194.02	
194.03	07953	0	0	0	0	0	194.03	
194.04	07954	0	0	0	0	0	194.04	
194.05	07955	0	20,514	0	0	0	194.05	
194.06	07956	0	0	0	0	0	194.06	
194.07	07957	0	0	0	0	0	194.07	
194.08	07958	0	0	0	0	0	194.08	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet B-1

Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Description		DATA PROCESSING (TERMINALS)	PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	ADMITTING (TOTAL REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (TOTAL REVENUE)	Reconciliation	
		5.02	5.03	5.04	5.05	5A.06	
194.09	07959 REID HEALTH PAVILION - RES	23	24,769	0	0	0	194.09
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)	19,771,849	373,807	11,220,143	226,943		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	13,459.393465	0.037387	0.009672	0.000196		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	141,178	242,458	179,551	231,553		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	96.104833	0.024250	0.000155	0.000200		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0048		Period: From 01/01/2022 To 12/31/2022		Worksheet B-1		
Date/Time Prepared: 5/23/2023 11:46 am								
Cost Center Description		OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)		
		5.06	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE					1.01	
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	00550	DATA PROCESSING					5.02	
5.03	00560	PURCHASING RECEIVING AND STORES					5.03	
5.04	00570	ADMITTING					5.04	
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05	
5.06	00590	OTHER A&G	342,441,773				5.06	
7.00	00700	OPERATION OF PLANT	345,723	954,446			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	1,394,073	12,335	2,218,132		8.00	
9.00	00900	HOUSEKEEPING	4,874,059	7,872	0	13,108	9.00	
10.00	01000	DIETARY	3,817,465	18,310	0	421	10.00	
11.00	01100	CAFETERIA	2,499,523	9,461	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	440,884	1,955	0	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	6,942,089	8,411	0	151	14.00	
15.00	01500	PHARMACY	47,246,232	9,640	0	167	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	137,008	0	0	0	16.00	
17.00	01700	SOCIAL SERVICE	5,509,486	438	0	54	17.00	
17.01	01701	INSERVICE EDUCATION	3,970,502	9,322	0	163	17.01	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,482,692	0	0	0	21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	679,589	0	0	0	22.00	
23.00	02300	PARAMED PRGM	634,225	2,807	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	42,479,713	108,244	757,843	6,111	36,117	30.00
31.00	03100	INTENSIVE CARE UNIT	8,833,779	24,552	159,791	935	5,037	31.00
40.00	04000	SUBPROVIDER - I PF	3,967,018	22,340	163,102	487	4,631	40.00
41.00	04100	SUBPROVIDER - I RF	2,939,702	17,898	70,614	422	3,849	41.00
43.00	04300	NURSERY	939,233	2,681	0	42	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	37,364,476	40,624	176,635	1,088	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,536,003	8,316	105,433	177	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,662,220	53,880	217,506	448	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	11,098,719	4,593	103,462	140	0	59.00
60.00	06000	LABORATORY	19,954,590	20,194	1,367	331	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,286,150	1,194	0	62	0	65.00
66.00	06600	PHYSICAL THERAPY	16,125,016	48,220	18,826	95	0	66.00
69.00	06900	ELECTROCARDIOLOGY	4,352,197	557	0	140	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,156,771	5,400	8,993	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	19,798,659	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,504,577	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,027,551	1,490	0	162	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,062,429	3,662	0	40	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	15,882,576	30,962	299,606	893	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	3,007,819	0	65,950	215	0	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	660,959	3,752	0	10	0	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	4,404,143	0	0	191	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	311,017,850	479,110	2,149,128	12,945	49,634	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,228,695	108,173	59,930	140	0	192.00
194.00	07950	RENTAL SPACE	6,496,919	22,920	0	0	0	194.00
194.01	07951	FOUNDATION	429,667	206	0	8	0	194.01
194.02	07952	RETAIL SERVICES	304,340	684	0	15	0	194.02
194.03	07953	REID CONTRACTED SERVICES	197,496	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	9,055	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	1,458,066	0	0	0	0	194.05
194.06	07956	VACANT SPACE	2,670,982	93,036	0	0	0	194.06
194.07	07957	HOME OFFICE	8,941,459	242,803	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
194.09	07959	REID HEALTH PAVILION - RES	2,687,244	7,514	9,074	0	0	194.09

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet B-1

Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Description		OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.06	7.00	8.00	9.00	10.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	41,999,082	388,125	1,570,066	5,475,044	4,468,954	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.122646	0.406650	0.707833	417.687214	90.038159	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	215,730	345,941	402,217	323,400	653,216	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000630	0.362452	0.181331	24.671956	13.160656	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0048		Period: From 01/01/2022 To 12/31/2022		Worksheet B-1	
Cost Center Description		CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (MED SUPPLIES)	PHARMACY (DRUGS)	MEDICAL RECORDS & LIBRARY (TOTAL REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	2,646,557					11.00
13.00	01300	2,080	1,572,677				13.00
14.00	01400	32,194	0	24,398,282			14.00
15.00	01500	126,965	0	24,391	38,556,839		15.00
16.00	01600	0	0	0	0	1,160,060,725	16.00
17.00	01700	97,755	0	0	0	0	17.00
17.01	01701	42,426	0	0	603	0	17.01
21.00	02100	39,463	0	0	0	0	21.00
22.00	02200	4,567	0	0	0	0	22.00
23.00	02300	6,729	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	694,184	694,184	73,346	839	76,685,350	30.00
31.00	03100	106,603	106,603	73,850	873	10,656,052	31.00
40.00	04000	65,454	65,454	520	0	5,073,786	40.00
41.00	04100	44,305	44,305	2,565	8	4,173,816	41.00
43.00	04300	13,424	13,424	0	0	1,320,590	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	58,838	58,838	11,797,464	147,740	192,082,267	50.00
52.00	05200	15,887	15,887	42,884	3,039	8,104,428	52.00
54.00	05400	237,696	237,696	183,652	688,788	201,589,585	54.00
59.00	05900	53,182	53,182	10,433,327	328	117,994,072	59.00
60.00	06000	197,990	0	1,216,549	0	125,109,226	60.00
65.00	06500	46,362	46,362	18,756	68	27,510,977	65.00
66.00	06600	239,147	0	496	55	25,832,875	66.00
69.00	06900	42,606	0	222,931	226,405	30,728,297	69.00
70.00	07000	16,411	0	44	0	7,085,048	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	42,270,688	72.00
73.00	07300	0	0	0	37,254,518	152,470,298	73.00
74.00	07400	9	9	0	0	1,296,107	74.00
76.00	03950	0	0	0	0	0	76.00
76.97	07697	18,024	18,024	454	0	1,933,167	76.97
77.00	07700	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	218,709	218,709	61,197	104,572	113,568,281	91.00
92.00	09200						92.00
93.00	04040	71,539	0	0	18,488	7,722,846	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	15,260	0	245,637	620	469,944	96.00
102.00	10200	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	57,547	0	219	96,128	6,383,025	116.00
118.00		2,565,356	1,572,677	24,398,282	38,543,072	1,160,060,725	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	6,432	0	0	0	0	194.01
194.02	07952	8,063	0	0	0	0	194.02
194.03	07953	4,944	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet B-1

Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Description		CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (MED SUPPLIES)	PHARMACY (DRUGS)	MEDICAL RECORDS & LIBRARY (TOTAL REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
194.09	07959 REID HEALTH PAVILION - RES	61,762	0	0	13,767	0	194.09
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)	2,809,926	497,960	7,894,180	53,257,129	153,811	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.061729	0.316632	0.323555	1.381263	0.000133	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	267,813	54,621	453,548	1,328,062	137,094	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.101193	0.034731	0.018589	0.034444	0.000118	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet B-1 Date/Time Prepared: 5/23/2023 11:46 am
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Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INSERVICE EDUCATION (IN HOUSE E D)	INTERNS & RESIDENTS		PARAMED PRGM (TIME SPENT)	
			SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
	17.00	17.01	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	NEW CAP BLDG & FIXT - OFFSITE					1.01
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 00550	DATA PROCESSING					5.02
5.03 00560	PURCHASING RECEIVING AND STORES					5.03
5.04 00570	ADMITTING					5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06 00590	OTHER A&G					5.06
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	55,729				17.00
17.01 01701	INSERVICE EDUCATION	0	43,382			17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	1,629		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	1,629	22.00
23.00 02300	PARAMED PRGM	0	126			100 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	36,858	12,684	1,199	1,199	0 30.00
31.00 03100	INTENSIVE CARE UNIT	4,349	1,863	47	47	0 31.00
40.00 04000	SUBPROVIDER - I PF	0	1,154	0	0	0 40.00
41.00 04100	SUBPROVIDER - I RF	0	778	0	0	0 41.00
43.00 04300	NURSERY	0	235	0	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	2,866	82	82	0 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	281	0	0	0 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	4,421	25	25	100 54.00
59.00 05900	CARDIAC CATHETERIZATION	0	927	0	0	0 59.00
60.00 06000	LABORATORY	0	3,590	0	0	0 60.00
65.00 06500	RESPIRATORY THERAPY	0	900	0	0	0 65.00
66.00 06600	PHYSICAL THERAPY	0	4,341	0	0	0 66.00
69.00 06900	ELECTROCARDIOLOGY	0	823	42	42	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	284	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 - OTHER	0	0	0	0	0 76.00
76.97 07697	CARDIAC REHABILITATION	0	313	0	0	0 76.97
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0 77.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	14,522	4,232	101	101	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00 04040	FAMILY PRACTICE	0	1,251	0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	265	0	0	0 96.00
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0 102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	0	711			0 116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	55,729	42,045	1,496	1,496	100 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	133	133	0 192.00
194.00 07950	RENTAL SPACE	0	0	0	0	0 194.00
194.01 07951	FOUNDATION	0	111	0	0	0 194.01
194.02 07952	RETAIL SERVICES	0	140	0	0	0 194.02
194.03 07953	REID CONTRACTED SERVICES	0	0	0	0	0 194.03
194.04 07954	REID PHYSICIAN ASSOC.	0	0	0	0	0 194.04
194.05 07955	CONNERSVILLE LOCATION	0	0	0	0	0 194.05
194.06 07956	VACANT SPACE	0	0	0	0	0 194.06

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet B-1

Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INSERVICE EDUCATION (IN HOUSE E D)	INTERNS & RESIDENTS		PARAMED PRGM (TIME SPENT)	
			SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
	17.00	17.01	21.00	22.00	23.00	
194.07 07957 HOME OFFICE	0	0	0	0	0	194.07
194.08 07958 CAMBRIDGE RHC	0	0	0	0	0	194.08
194.09 07959 REID HEALTH PAVILION - RES	0	1,086	0	0	0	194.09
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)	6,311,724	4,575,220	2,829,083	767,787	733,583	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	113.257442	105.463556	1,736.699202	471.324125	7,335.830000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	55,053	322,758	5,773	17,210	114,743	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.987870	7.439906	3.543892	10.564764	1,147.430000	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						0 206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet C
Part I
Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII				
				Hospital				
				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	60,578,583		60,578,583	997	60,579,580	30.00
31.00	03100	INTENSIVE CARE UNIT	11,746,847		11,746,847	0	11,746,847	31.00
40.00	04000	SUBPROVIDER - IPF	5,411,239		5,411,239	0	5,411,239	40.00
41.00	04100	SUBPROVIDER - IRF	4,024,842		4,024,842	0	4,024,842	41.00
43.00	04300	NURSERY	1,116,522		1,116,522	0	1,116,522	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	46,973,168		46,973,168	0	46,973,168	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,947,014		1,947,014	0	1,947,014	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,982,493		33,982,493	0	33,982,493	54.00
59.00	05900	CARDIAC CATHETERIZATION	16,156,480		16,156,480	0	16,156,480	59.00
60.00	06000	LABORATORY	23,548,462		23,548,462	0	23,548,462	60.00
65.00	06500	RESPIRATORY THERAPY	5,006,855	0	5,006,855	0	5,006,855	65.00
66.00	06600	PHYSICAL THERAPY	18,890,698	0	18,890,698	0	18,890,698	66.00
69.00	06900	ELECTROCARDIOLOGY	5,465,655		5,465,655	0	5,465,655	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,355,538		1,355,538	0	1,355,538	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,232,507		22,232,507	0	22,232,507	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	53,167,667		53,167,667	0	53,167,667	73.00
74.00	07400	RENAL DIALYSIS	1,222,032		1,222,032	0	1,222,032	74.00
76.00	03950	ANCILLARY - OTHER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,269,186		1,269,186	0	1,269,186	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	21,000,021		21,000,021	0	21,000,021	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	10,016,785		10,016,785	0	10,016,785	92.00
93.00	04040	FAMILY PRACTICE	3,747,655		3,747,655	0	3,747,655	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	872,272		872,272	0	872,272	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	5,293,854		5,293,854		5,293,854	116.00
200.00		Subtotal (see instructions)	355,026,375	0	355,026,375	997	355,027,372	200.00
201.00		Less Observation Beds	10,016,785		10,016,785		10,016,785	201.00
202.00		Total (see instructions)	345,009,590	0	345,009,590	997	345,010,587	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/23/2023 11:46 am
		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	59,857,044		59,857,044	30.00
31.00	03100	INTENSIVE CARE UNIT	10,656,052		10,656,052	31.00
40.00	04000	SUBPROVIDER - IPF	5,073,786		5,073,786	40.00
41.00	04100	SUBPROVIDER - IRF	4,173,816		4,173,816	41.00
43.00	04300	NURSERY	1,320,590		1,320,590	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,431,781	146,650,486	192,082,267	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,088,476	1,015,952	8,104,428	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,773,798	155,815,787	201,589,585	54.00
59.00	05900	CARDIAC CATHETERIZATION	43,444,518	74,549,554	117,994,072	59.00
60.00	06000	LABORATORY	44,148,962	80,960,264	125,109,226	60.00
65.00	06500	RESPIRATORY THERAPY	22,587,917	4,923,060	27,510,977	65.00
66.00	06600	PHYSICAL THERAPY	8,673,566	17,159,309	25,832,875	66.00
69.00	06900	ELECTROCARDIOLOGY	6,433,630	24,294,667	30,728,297	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,534	7,080,514	7,085,048	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,198,997	26,071,691	42,270,688	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,291,203	95,179,095	152,470,298	73.00
74.00	07400	RENAL DIALYSIS	1,132,276	163,831	1,296,107	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	700	1,932,467	1,933,167	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	33,486,656	80,081,625	113,568,281	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,316,464	12,511,842	16,828,306	92.00
93.00	04040	FAMILY PRACTICE	21,972	7,700,874	7,722,846	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	469,944	469,944	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	1,924,127	4,458,898	6,383,025	116.00
200.00		Subtotal (see instructions)	419,040,865	741,019,860	1,160,060,725	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	419,040,865	741,019,860	1,160,060,725	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/23/2023 11:46 am
Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital
			11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.244547		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.240241		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168573		54.00
59.00	05900	CARDIAC CATHETERIZATION	0.136926		59.00
60.00	06000	LABORATORY	0.188223		60.00
65.00	06500	RESPIRATORY THERAPY	0.181995		65.00
66.00	06600	PHYSICAL THERAPY	0.731266		66.00
69.00	06900	ELECTROCARDIOLOGY	0.177870		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.191324		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.525956		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348708		73.00
74.00	07400	RENAL DIALYSIS	0.942848		74.00
76.00	03950	ANCILLARY - OTHER	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.656532		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.184911		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.595234		92.00
93.00	04040	FAMILY PRACTICE	0.485269		93.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.856119		96.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
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: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet C
Part I
Date/Time Prepared:
5/23/2023 11:46 am

		Title XIX		Hospital		Cost
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	60,578,583		60,578,583	997	60,579,580
31.00	03100 INTENSIVE CARE UNIT	11,746,847		11,746,847	0	11,746,847
40.00	04000 SUBPROVIDER - IPF	5,411,239		5,411,239	0	5,411,239
41.00	04100 SUBPROVIDER - IRF	4,024,842		4,024,842	0	4,024,842
43.00	04300 NURSERY	1,116,522		1,116,522	0	1,116,522
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	46,973,168		46,973,168	0	46,973,168
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,947,014		1,947,014	0	1,947,014
54.00	05400 RADIOLOGY-DIAGNOSTIC	33,982,493		33,982,493	0	33,982,493
59.00	05900 CARDIAC CATHETERIZATION	16,156,480		16,156,480	0	16,156,480
60.00	06000 LABORATORY	23,548,462		23,548,462	0	23,548,462
65.00	06500 RESPIRATORY THERAPY	5,006,855	0	5,006,855	0	5,006,855
66.00	06600 PHYSICAL THERAPY	18,890,698	0	18,890,698	0	18,890,698
69.00	06900 ELECTROCARDIOLOGY	5,465,655		5,465,655	0	5,465,655
70.00	07000 ELECTROENCEPHALOGRAPHY	1,355,538		1,355,538	0	1,355,538
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	22,232,507		22,232,507	0	22,232,507
73.00	07300 DRUGS CHARGED TO PATIENTS	53,167,667		53,167,667	0	53,167,667
74.00	07400 RENAL DIALYSIS	1,222,032		1,222,032	0	1,222,032
76.00	03950 ANCILLARY - OTHER	0		0	0	0
76.97	07697 CARDIAC REHABILITATION	1,269,186		1,269,186	0	1,269,186
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	21,000,021		21,000,021	0	21,000,021
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	10,016,785		10,016,785	0	10,016,785
93.00	04040 FAMILY PRACTICE	3,747,655		3,747,655	0	3,747,655
OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	872,272		872,272	0	872,272
102.00	10200 OPIOID TREATMENT PROGRAM	0		0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
116.00	11600 HOSPICE	5,293,854		5,293,854		5,293,854
200.00	Subtotal (see instructions)	355,026,375	0	355,026,375	997	355,027,372
201.00	Less Observation Beds	10,016,785		10,016,785		10,016,785
202.00	Total (see instructions)	345,009,590	0	345,009,590	997	345,010,587

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/23/2023 11:46 am
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		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	59,857,044		59,857,044		30.00
31.00	03100	INTENSIVE CARE UNIT	10,656,052		10,656,052		31.00
40.00	04000	SUBPROVIDER - IPF	5,073,786		5,073,786		40.00
41.00	04100	SUBPROVIDER - IRF	4,173,816		4,173,816		41.00
43.00	04300	NURSERY	1,320,590		1,320,590		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	45,431,781	146,650,486	192,082,267	0.244547	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,088,476	1,015,952	8,104,428	0.240241	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,773,798	155,815,787	201,589,585	0.168573	54.00
59.00	05900	CARDIAC CATHETERIZATION	43,444,518	74,549,554	117,994,072	0.136926	59.00
60.00	06000	LABORATORY	44,148,962	80,960,264	125,109,226	0.188223	60.00
65.00	06500	RESPIRATORY THERAPY	22,587,917	4,923,060	27,510,977	0.181995	65.00
66.00	06600	PHYSICAL THERAPY	8,673,566	17,159,309	25,832,875	0.731266	66.00
69.00	06900	ELECTROCARDIOLOGY	6,433,630	24,294,667	30,728,297	0.177870	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,534	7,080,514	7,085,048	0.191324	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,198,997	26,071,691	42,270,688	0.525956	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,291,203	95,179,095	152,470,298	0.348708	73.00
74.00	07400	RENAL DIALYSIS	1,132,276	163,831	1,296,107	0.942848	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	700	1,932,467	1,933,167	0.656532	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	33,486,656	80,081,625	113,568,281	0.184911	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,316,464	12,511,842	16,828,306	0.595234	92.00
93.00	04040	FAMILY PRACTICE	21,972	7,700,874	7,722,846	0.485269	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	469,944	469,944	1.856119	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	1,924,127	4,458,898	6,383,025		116.00
200.00		Subtotal (see instructions)	419,040,865	741,019,860	1,160,060,725		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	419,040,865	741,019,860	1,160,060,725		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/23/2023 11:46 am
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	96.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
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: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part I Date/Time Prepared: 5/23/2023 11:46 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	4,730,137	0	4,730,137	43,272	109.31	30.00
31.00	INTENSIVE CARE UNIT	1,290,451		1,290,451	5,037	256.19	31.00
40.00	SUBPROVIDER - IPF	778,478	0	778,478	4,631	168.10	40.00
41.00	SUBPROVIDER - IRF	612,341	0	612,341	3,810	160.72	41.00
43.00	NURSERY	94,393		94,393	1,417	66.61	43.00
200.00	Total (lines 30 through 199)	7,505,800		7,505,800	58,167		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	14,946	1,633,747				
31.00	INTENSIVE CARE UNIT	1,904	487,786				
40.00	SUBPROVIDER - IPF	1,864	313,338				
41.00	SUBPROVIDER - IRF	1,643	264,063				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	20,357	2,698,934				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Prepared: 5/23/2023 11:46 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital		Capital Costs (column 3 x column 4)	
					Inpatient Program Charges	PPS		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,907,280	192,082,267	0.020342	22,144,659	450,467	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	299,838	8,104,428	0.036997	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,550,974	201,589,585	0.027536	19,959,936	549,617	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,617,236	117,994,072	0.013706	20,930,405	286,872	59.00
60.00	06000	LABORATORY	1,770,781	125,109,226	0.014154	18,102,040	256,216	60.00
65.00	06500	RESPIRATORY THERAPY	194,512	27,510,977	0.007070	10,130,559	71,623	65.00
66.00	06600	PHYSICAL THERAPY	1,661,322	25,832,875	0.064310	2,433,679	156,510	66.00
69.00	06900	ELECTROCARDIOLOGY	496,827	30,728,297	0.016168	2,993,954	48,406	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	160,835	7,085,048	0.022701	3,942	89	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,467	42,270,688	0.000768	9,670,680	7,427	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,356,271	152,470,298	0.008895	22,984,014	204,443	73.00
74.00	07400	RENAL DIALYSIS	57,275	1,296,107	0.044190	579,986	25,630	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	238,846	1,933,167	0.123552	330	41	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,471,796	113,568,281	0.012960	14,703,522	190,558	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	782,121	16,828,306	0.046477	1,759,989	81,799	92.00
93.00	04040	FAMILY PRACTICE	106,575	7,722,846	0.013800	21,972	303	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	148,331	469,944	0.315635	0	0	96.00
200.00		Total (lines 50 through 199)	19,853,287	1,072,596,412		146,419,667	2,330,001	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Prepared: 5/23/2023 11:46 am
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Cost Center Description		Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
		1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	200.00
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
		4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	43,272	0.00	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	5,037	0.00	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,631	0.00	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	3,810	0.00	41.00
43.00	04300	NURSERY	0	0	1,417	0.00	43.00
200.00		Total (lines 30 through 199)	0	0	58,167		200.00
Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
		9.00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0				31.00
40.00	04000	SUBPROVIDER - IPF	0				40.00
41.00	04100	SUBPROVIDER - IRF	0				41.00
43.00	04300	NURSERY	0				43.00
200.00		Total (lines 30 through 199)	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/23/2023 11:46 am
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Cost Center Description	Title XVIII				Hospital			
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	PPS		
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	733,583	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
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 - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
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
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	733,583	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/23/2023 11:46 am
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Cost Center Description	Title XVIII		Hospital		Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)		
	4.00	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	192,082,267	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	8,104,428	0.000000	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	733,583	733,583	201,589,585	0.003639	54.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	117,994,072	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	125,109,226	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	27,510,977	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	25,832,875	0.000000	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	30,728,297	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	7,085,048	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	42,270,688	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	152,470,298	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	1,296,107	0.000000	74.00
76.00 03950 ANCILLARY - OTHER	0	0	0	0	0.000000	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	1,933,167	0.000000	76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	0	0	113,568,281	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	16,828,306	0.000000	92.00
93.00 04040 FAMILY PRACTICE	0	0	0	7,722,846	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	469,944	0.000000	96.00
200.00 Total (lines 50 through 199)	0	733,583	733,583	1,072,596,412		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/23/2023 11:46 am
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Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	22,144,659	0	45,157,937	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	1,086	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.003639	19,959,936	72,634	45,797,547	166,657	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	20,930,405	0	30,345,463	0	59.00
60.00	06000 LABORATORY	0.000000	18,102,040	0	10,219,319	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	10,130,559	0	1,363,685	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	2,433,679	0	106,251	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	2,993,954	0	8,637,927	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	3,942	0	2,021,054	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	9,670,680	0	9,169,156	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	22,984,014	0	35,626,412	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	579,986	0	56,627	0	74.00
76.00	03950 ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	330	0	922,030	0	76.97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0.000000	14,703,522	0	16,126,515	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,759,989	0	1,991,577	0	92.00
93.00	04040 FAMILY PRACTICE	0.000000	21,972	0	3,014,167	0	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00	Total (lines 50 through 199)		146,419,667	72,634	210,556,753	166,657	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/23/2023 11:46 am
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0.244547	45,157,937	0	0	11,043,238	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.240241	1,086	0	0	261	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.168573	45,797,547	0	0	7,720,230	54.00	
59.00 05900 CARDIAC CATHETERIZATION	0.136926	30,345,463	0	0	4,155,083	59.00	
60.00 06000 LABORATORY	0.188223	10,219,319	0	0	1,923,511	60.00	
65.00 06500 RESPIRATORY THERAPY	0.181995	1,363,685	0	850	248,184	65.00	
66.00 06600 PHYSICAL THERAPY	0.731266	106,251	0	0	77,698	66.00	
69.00 06900 ELECTROCARDIOLOGY	0.177870	8,637,927	0	0	1,536,428	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0.191324	2,021,054	0	0	386,676	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.525956	9,169,156	0	0	4,822,573	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.348708	35,626,412	0	70,114	12,423,215	73.00	
74.00 07400 RENAL DIALYSIS	0.942848	56,627	0	0	53,391	74.00	
76.00 03950 ANCILLARY - OTHER	0.000000	0	0	0	0	76.00	
76.97 07697 CARDIAC REHABILITATION	0.656532	922,030	0	0	605,342	76.97	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00	
OUTPATIENT SERVICE COST CENTERS							
91.00 09100 EMERGENCY	0.184911	16,126,515	0	0	2,981,970	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.595234	1,991,577	0	0	1,185,454	92.00	
93.00 04040 FAMILY PRACTICE	0.485269	3,014,167	0	0	1,462,682	93.00	
OTHER REIMBURSABLE COST CENTERS							
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	1.856119	0	0	0	0	96.00	
200.00		Subtotal (see instructions)	210,556,753	0	70,964	50,625,936	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0	0		201.00
202.00		Net Charges (Line 200 - Line 201)	210,556,753	0	70,964	50,625,936	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/23/2023 11:46 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
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
65.00	06500 RESPIRATORY THERAPY	0	155	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	24,449	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03950 ANCILLARY - OTHER	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	77.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00	Subtotal (see instructions)	0	24,604	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	24,604	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0048 Component CCN: 15-S048		Period: From 01/01/2022 To 12/31/2022		Worksheet D Part II Date/Time Prepared: 5/23/2023 11:46 am		
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	3,907,280	192,082,267	0.020342	41,181	838	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	299,838	8,104,428	0.036997	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,550,974	201,589,585	0.027536	189,305	5,213	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,617,236	117,994,072	0.013706	1,839	25	59.00
60.00	06000	LABORATORY	1,770,781	125,109,226	0.014154	373,716	5,290	60.00
65.00	06500	RESPIRATORY THERAPY	194,512	27,510,977	0.007070	96,976	686	65.00
66.00	06600	PHYSICAL THERAPY	1,661,322	25,832,875	0.064310	141,045	9,071	66.00
69.00	06900	ELECTROCARDIOLOGY	496,827	30,728,297	0.016168	18,172	294	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	160,835	7,085,048	0.022701	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,467	42,270,688	0.000768	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,356,271	152,470,298	0.008895	552,179	4,912	73.00
74.00	07400	RENAL DIALYSIS	57,275	1,296,107	0.044190	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	238,846	1,933,167	0.123552	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,471,796	113,568,281	0.012960	335,583	4,349	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	16,828,306	0.000000	0	0	92.00
93.00	04040	FAMILY PRACTICE	106,575	7,722,846	0.013800	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	148,331	469,944	0.315635	0	0	96.00
200.00		Total (lines 50 through 199)	19,071,166	1,072,596,412		1,749,996	30,678	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/23/2023 11:46 am
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Cost Center Description		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	733,583	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
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 - OTHER	0	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
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
93.00	04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00	Total (lines 50 through 199)	0	0	0	0	733,583	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/23/2023 11:46 am		
		Title XVIII	Subprovider - LPE	PPS		
Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 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	192,082,267	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	8,104,428	0.000000	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	733,583	201,589,585	0.003639	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	117,994,072	0.000000	59.00
60.00	06000 LABORATORY	0	0	125,109,226	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	27,510,977	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	25,832,875	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	30,728,297	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	7,085,048	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	42,270,688	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	152,470,298	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	1,296,107	0.000000	74.00
76.00	03950 ANCILLARY - OTHER	0	0	0	0.000000	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	1,933,167	0.000000	76.97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0	113,568,281	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	16,828,306	0.000000	92.00
93.00	04040 FAMILY PRACTICE	0	0	7,722,846	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	469,944	0.000000	96.00
200.00	Total (lines 50 through 199)	0	733,583	1,072,596,412		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-0048 Component CCN: 15-S048		Period: From 01/01/2022 To 12/31/2022		Worksheet D Part IV Date/Time Prepared: 5/23/2023 11:46 am	
			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)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	41,181	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.003639	189,305	689	799	3	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,839	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	373,716	0	2,730	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	96,976	0	230	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	141,045	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	18,172	0	967	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	0	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	552,179	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.000000	335,583	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	236	0	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		1,749,996	689	4,962	3	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/23/2023 11:46 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.244547	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.240241	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.168573	799	0	0	135	54.00
59.00 05900 CARDIAC CATHETERIZATION	0.136926	0	0	0	0	59.00
60.00 06000 LABORATORY	0.188223	2,730	0	0	514	60.00
65.00 06500 RESPIRATORY THERAPY	0.181995	230	0	0	42	65.00
66.00 06600 PHYSICAL THERAPY	0.731266	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0.177870	967	0	0	172	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.191324	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.525956	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.348708	0	0	129	0	73.00
74.00 07400 RENAL DIALYSIS	0.942848	0	0	0	0	74.00
76.00 03950 ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0.656532	0	0	0	0	76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0.184911	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.595234	0	0	0	0	92.00
93.00 04040 FAMILY PRACTICE	0.485269	236	0	0	115	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	1.856119	0	0	0	0	96.00
200.00	Subtotal (see instructions)	4,962	0	129	978	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)	4,962	0	129	978	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/23/2023 11:46 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
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
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	45	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03950 ANCILLARY - OTHER	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	77.00
OUTPATIENT SERVICE COST CENTERS			
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.00 04040 FAMILY PRACTICE	0	0	93.00
OTHER REIMBURSABLE COST CENTERS			
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00 Subtotal (see instructions)	0	45	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	45	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0048 Component CCN: 15-T048		Period: From 01/01/2022 To 12/31/2022		Worksheet D Part II Date/Time Prepared: 5/23/2023 11:46 am		
Title XVIII				Subprovider - IRF		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	3,907,280	192,082,267	0.020342	85,993	1,749	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	299,838	8,104,428	0.036997	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,550,974	201,589,585	0.027536	108,412	2,985	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,617,236	117,994,072	0.013706	5,060	69	59.00
60.00	06000	LABORATORY	1,770,781	125,109,226	0.014154	316,518	4,480	60.00
65.00	06500	RESPIRATORY THERAPY	194,512	27,510,977	0.007070	284,051	2,008	65.00
66.00	06600	PHYSICAL THERAPY	1,661,322	25,832,875	0.064310	1,505,573	96,823	66.00
69.00	06900	ELECTROCARDIOLOGY	496,827	30,728,297	0.016168	2,901	47	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	160,835	7,085,048	0.022701	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,467	42,270,688	0.000768	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,356,271	152,470,298	0.008895	492,093	4,377	73.00
74.00	07400	RENAL DIALYSIS	57,275	1,296,107	0.044190	19,405	858	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	238,846	1,933,167	0.123552	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,471,796	113,568,281	0.012960	1,445	19	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	16,828,306	0.000000	0	0	92.00
93.00	04040	FAMILY PRACTICE	106,575	7,722,846	0.013800	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	148,331	469,944	0.315635	0	0	96.00
200.00		Total (lines 50 through 199)	19,071,166	1,072,596,412		2,821,451	113,415	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/23/2023 11:46 am
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Cost Center Description		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	733,583	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
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 - OTHER	0	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
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
93.00	04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00	Total (lines 50 through 199)	0	0	0	0	733,583	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/23/2023 11:46 am		
		Title XVIII	Subprovider - IRF	PPS		
Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 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	192,082,267	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	8,104,428	0.000000	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	733,583	201,589,585	0.003639	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	117,994,072	0.000000	59.00
60.00	06000 LABORATORY	0	0	125,109,226	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	27,510,977	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	25,832,875	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	30,728,297	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	7,085,048	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	42,270,688	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	152,470,298	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	1,296,107	0.000000	74.00
76.00	03950 ANCILLARY - OTHER	0	0	0	0.000000	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	1,933,167	0.000000	76.97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0	113,568,281	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	16,828,306	0.000000	92.00
93.00	04040 FAMILY PRACTICE	0	0	7,722,846	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	469,944	0.000000	96.00
200.00	Total (lines 50 through 199)	0	733,583	1,072,596,412		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0048 Component CCN: 15-T048		Period: From 01/01/2022 To 12/31/2022		Worksheet D Part IV Date/Time Prepared: 5/23/2023 11:46 am	
				Title XVIII		Subprovider - IRF	PPS
Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	85,993	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.003639	108,412	395	0	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	5,060	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	316,518	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	284,051	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	1,505,573	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	2,901	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	0	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	492,093	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	19,405	0	0	0	74.00
76.00	03950 ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0.000000	1,445	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0.000000	0	0	468	0	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00	Total (lines 50 through 199)		2,821,451	395	468	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/23/2023 11:46 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.244547	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.240241	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.168573	0	0	0	0	54.00
59.00 05900 CARDIAC CATHETERIZATION	0.136926	0	0	0	0	59.00
60.00 06000 LABORATORY	0.188223	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.181995	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.731266	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0.177870	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.191324	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.525956	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.348708	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0.942848	0	0	0	0	74.00
76.00 03950 ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0.656532	0	0	0	0	76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0.184911	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.595234	0	0	0	0	92.00
93.00 04040 FAMILY PRACTICE	0.485269	468	0	0	227	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	1.856119	0	0	0	0	96.00
200.00	Subtotal (see instructions)		468	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		468	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/23/2023 11:46 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
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
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 - OTHER	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	77.00
OUTPATIENT SERVICE COST CENTERS			
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.00 04040 FAMILY PRACTICE	0	0	93.00
OTHER REIMBURSABLE COST CENTERS			
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00 Subtotal (see instructions)	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/23/2023 11:46 am
	Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.244547	0	2,016,545	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.240241	0	31,349	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.168573	0	3,082,628	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.136926	0	825,445	0	0
60.00 06000 LABORATORY	0.188223	0	1,572,393	0	0
65.00 06500 RESPIRATORY THERAPY	0.181995	0	107,520	0	0
66.00 06600 PHYSICAL THERAPY	0.731266	0	601,080	0	0
69.00 06900 ELECTROCARDIOLOGY	0.177870	0	274,942	0	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0.191324	0	59,399	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.525956	0	284,405	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.348708	0	1,605,549	0	0
74.00 07400 RENAL DIALYSIS	0.942848	0	5,759	0	0
76.00 03950 ANCILLARY - OTHER	0.000000	0	0	0	0
76.97 07697 CARDIAC REHABILITATION	0.656532	0	20,977	0	0
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
91.00 09100 EMERGENCY	0.184911	0	2,638,175	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.595234	0	405,880	0	0
93.00 04040 FAMILY PRACTICE	0.485269	0	134,818	0	0
OTHER REIMBURSABLE COST CENTERS					
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	1.856119	0	0	0	0
200.00	Subtotal (see instructions)	0	13,666,864	0	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0	0
202.00	Net Charges (line 200 - line 201)	0	13,666,864	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/23/2023 11:46 am
		Title XIX	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	493,140	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7,531	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	519,648	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	113,025	0	59.00
60.00	06000 LABORATORY	295,961	0	60.00
65.00	06500 RESPIRATORY THERAPY	19,568	0	65.00
66.00	06600 PHYSICAL THERAPY	439,549	0	66.00
69.00	06900 ELECTROCARDIOLOGY	48,904	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	11,364	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	149,585	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	559,868	0	73.00
74.00	07400 RENAL DIALYSIS	5,430	0	74.00
76.00	03950 ANCILLARY - OTHER	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	13,772	0	76.97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	77.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	487,828	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	241,594	0	92.00
93.00	04040 FAMILY PRACTICE	65,423	0	93.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00	Subtotal (see instructions)	3,472,190	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	3,472,190	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/23/2023 11:46 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		43,272	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		43,272	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)		36,117	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)		14,946	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)		60,579,580	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)		60,579,580	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)		60,579,580	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)		1,399.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		20,923,952	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)		20,923,952	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/23/2023 11:46 am		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	11,746,847	5,037	2,332.11	1,904	4,440,337	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				36,635,148		48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)				0		48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)				61,999,437		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)				2,121,533		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				2,402,635		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				4,524,168		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)				57,475,269		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges				0		54.00
55.00	Target amount per discharge				0.00		55.00
55.01	Permanent adjustment amount per discharge				0.00		55.01
55.02	Adjustment amount per discharge (contractor use only)				0.00		55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)				0		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0		57.00
58.00	Bonus payment (see instructions)				0		58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)				0.00		59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)				0.00		60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)				0		61.00
62.00	Relief payment (see instructions)				0		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only): for CAH, see instructions				0		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)				7,155		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,399.97		88.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0048		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/23/2023 11:46 am	
Cost Center Description			Title XVIII		Hospital		PPS	
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1.00		10,016,785 89.00	
Cost Center Description			Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
			1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
90.00	Capital-related cost	4,730,137	60,579,580	0.078081	10,016,785	782,121	90.00	
91.00	Nursing Program cost	0	60,579,580	0.000000	10,016,785	0	91.00	
92.00	Allied health cost	0	60,579,580	0.000000	10,016,785	0	92.00	
93.00	All other Medical Education	0	60,579,580	0.000000	10,016,785	0	93.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/23/2023 11:46 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,631	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,631	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)		4,631	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)		1,864	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)		5,411,239	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)		5,411,239	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)		5,411,239	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)		1,168.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,178,047	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,178,047	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1
				Component CCN: 15-S048		Date/Time Prepared: 5/23/2023 11:46 am
				Title XVIII	Subprovider - IPF	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	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					491,201	48.00
48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00 Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					2,669,248	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)					313,338	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					31,367	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					344,705	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,324,543	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
55.01 Permanent adjustment amount per discharge					0.00	55.01
55.02 Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0048 Component CCN: 15-S048		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/23/2023 11:46 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description						1.00	
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
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	778,478	5,411,239	0.143863	0	0	90.00
91.00	Nursing Program cost	0	5,411,239	0.000000	0	0	91.00
92.00	Allied health cost	0	5,411,239	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,411,239	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/23/2023 11:46 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,810 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,810 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			3,810 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)			1,643 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)			4,024,842 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)			4,024,842 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)			4,024,842 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)			1,056.39 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,735,649 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)			1,735,649 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1	
				Component CCN: 15-T048	Date/Time Prepared: 5/23/2023 11:46 am		
				Title XVIII	Subprovider - IRF	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	0	0	0.00	0	0	43.00	
44.00 CORONARY CARE UNIT						44.00	
45.00 BURN INTENSIVE CARE UNIT						45.00	
46.00 SURGICAL INTENSIVE CARE UNIT						46.00	
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,442,919	48.00	
48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01	
49.00 Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					3,178,568	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)					264,063	50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					113,810	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					377,873	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,800,695	53.00	
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0	54.00	
55.00 Target amount per discharge					0.00	55.00	
55.01 Permanent adjustment amount per discharge					0.00	55.01	
55.02 Adjustment amount per discharge (contractor use only)					0.00	55.02	
56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00	
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00	
58.00 Bonus payment (see instructions)					0	58.00	
59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00	
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00	
61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00	
62.00 Relief payment (see instructions)					0	62.00	
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00	
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00	
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00	
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00	
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00	
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00	
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00	
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00	
72.00 Program routine service cost (line 9 x line 71)						72.00	
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00	
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00	
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00	
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00	
77.00 Program capital-related costs (line 9 x line 76)						77.00	
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00	
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00	
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	
81.00 Inpatient routine service cost per diem limitation						81.00	
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00	
83.00 Reasonable inpatient routine service costs (see instructions)						83.00	
84.00 Program inpatient ancillary services (see instructions)						84.00	
85.00 Utilization review - physician compensation (see instructions)						85.00	
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0	87.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0048 Component CCN: 15-T048		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/23/2023 11:46 am		
		Title XVIII		Subprovider - IRF		PPS		
Cost Center Description						1.00		
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
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
90.00	Capital-related cost	612,341	4,024,842	0.152140	0	0	90.00	
91.00	Nursing Program cost	0	4,024,842	0.000000	0	0	91.00	
92.00	Allied health cost	0	4,024,842	0.000000	0	0	92.00	
93.00	All other Medical Education	0	4,024,842	0.000000	0	0	93.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/23/2023 11:46 am
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		43,272	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		43,272	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)		36,117	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)		759	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)		1,417	15.00
16.00	Nursery days (title V or XIX only)		96	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)		60,578,583	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)		60,578,583	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)		60,578,583	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)		1,399.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,062,562	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)		1,062,562	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/23/2023 11:46 am
				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)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	1,116,522	1,417	787.95	96	75,643	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	11,746,847	5,037	2,332.11	101	235,543	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,994,683	48.00
48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00 Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					3,368,431	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)					0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
55.01 Permanent adjustment amount per discharge					0.00	55.01
55.02 Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only): for CAH, see instructions					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					7,155	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,399.95	88.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0048		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/23/2023 11:46 am	
Cost Center Description		Title XIX		Hospital		Cost	
Cost Center Description						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					10,016,642	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	4,730,137	60,578,583	0.078083	10,016,642	782,129	90.00
91.00	Nursing Program cost	0	60,578,583	0.000000	10,016,642	0	91.00
92.00	Allied health cost	0	60,578,583	0.000000	10,016,642	0	92.00
93.00	All other Medical Education	0	60,578,583	0.000000	10,016,642	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/23/2023 11:46 am
		Title XIX	Subprovider - IPF	Cost
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)			4,631 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			4,631 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)			4,631 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)			215 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)			1,417 15.00
16.00	Nursery days (title V or XIX only)			96 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)			5,411,239 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)			5,411,239 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)			5,411,239 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)			1,168.48 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			251,223 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)			251,223 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1	
				Component CCN: 15-S048	Date/Time Prepared: 5/23/2023 11:46 am		
				Title XIX	Subprovider - IPF	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)		
	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	0	0	0.00	0	0	43.00	
44.00 CORONARY CARE UNIT						44.00	
45.00 BURN INTENSIVE CARE UNIT						45.00	
46.00 SURGICAL INTENSIVE CARE UNIT						46.00	
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00	
48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01	
49.00 Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					251,223	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)					0	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00	
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0	54.00	
55.00 Target amount per discharge					0.00	55.00	
55.01 Permanent adjustment amount per discharge					0.00	55.01	
55.02 Adjustment amount per discharge (contractor use only)					0.00	55.02	
56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00	
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00	
58.00 Bonus payment (see instructions)					0	58.00	
59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00	
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00	
61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00	
62.00 Relief payment (see instructions)					0	62.00	
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00	
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00	
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00	
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00	
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00	
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00	
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00	
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00	
72.00 Program routine service cost (line 9 x line 71)						72.00	
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00	
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00	
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00	
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00	
77.00 Program capital-related costs (line 9 x line 76)						77.00	
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00	
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00	
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	
81.00 Inpatient routine service cost per diem limitation						81.00	
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00	
83.00 Reasonable inpatient routine service costs (see instructions)						83.00	
84.00 Program inpatient ancillary services (see instructions)						84.00	
85.00 Utilization review - physician compensation (see instructions)						85.00	
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0	87.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0048 Component CCN: 15-S048		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/23/2023 11:46 am	
		Title XIX		Subprovider - IPF		Cost	
Cost Center Description						1.00	
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
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	778,478	5,411,239	0.143863	0	0	90.00
91.00	Nursing Program cost	0	5,411,239	0.000000	0	0	91.00
92.00	Allied health cost	0	5,411,239	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,411,239	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/23/2023 11:46 am
		Title XIX	Subprovider - IRF	Cost
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)			3,810 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,810 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			3,810 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)			0 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)			1,417 15.00
16.00	Nursery days (title V or XIX only)			96 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)			4,024,842 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)			4,024,842 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)			4,024,842 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)			1,056.39 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			0 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)			0 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1	
				Component CCN: 15-T048	Date/Time Prepared: 5/23/2023 11:46 am		
				Title XIX	Subprovider - IRF	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)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				0	0	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)				0	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)				0	0	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	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				0	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				0	0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges				0	0	54.00
55.00	Target amount per discharge				0.00	0.00	55.00
55.01	Permanent adjustment amount per discharge				0.00	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)				0.00	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)				0	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	0	57.00
58.00	Bonus payment (see instructions)				0	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)				0.00	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)				0.00	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)				0	0	61.00
62.00	Relief payment (see instructions)				0	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0	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	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	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	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	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	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0	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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0048 Component CCN: 15-T048		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/23/2023 11:46 am	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description						1.00	
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
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	612,341	4,024,842	0.152140	0	0	90.00
91.00	Nursing Program cost	0	4,024,842	0.000000	0	0	91.00
92.00	Allied health cost	0	4,024,842	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,024,842	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/23/2023 11:46 am	
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		24,017,335	30.00
31.00	03100	INTENSIVE CARE UNIT		4,100,297	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.244547	22,144,659	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.240241	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168573	19,959,936	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.136926	20,930,405	59.00
60.00	06000	LABORATORY	0.188223	18,102,040	60.00
65.00	06500	RESPIRATORY THERAPY	0.181995	10,130,559	65.00
66.00	06600	PHYSICAL THERAPY	0.731266	2,433,679	66.00
69.00	06900	ELECTROCARDIOLOGY	0.177870	2,993,954	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.191324	3,942	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.525956	9,670,680	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348708	22,984,014	73.00
74.00	07400	RENAL DIALYSIS	0.942848	579,986	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.656532	330	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.184911	14,703,522	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.595234	1,759,989	92.00
93.00	04040	FAMILY PRACTICE	0.485269	21,972	93.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.856119	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		146,419,667	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)		146,419,667	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/23/2023 11:46 am	
		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
40.00	04000	SUBPROVIDER - IPF		2,041,993	40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.244547	41,181	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.240241	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168573	189,305	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.136926	1,839	59.00
60.00	06000	LABORATORY	0.188223	373,716	60.00
65.00	06500	RESPIRATORY THERAPY	0.181995	96,976	65.00
66.00	06600	PHYSICAL THERAPY	0.731266	141,045	66.00
69.00	06900	ELECTROCARDIOLOGY	0.177870	18,172	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.191324	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.525956	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348708	552,179	73.00
74.00	07400	RENAL DIALYSIS	0.942848	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.656532	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.184911	335,583	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.595234	0	92.00
93.00	04040	FAMILY PRACTICE	0.485269	0	93.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.856119	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,749,996	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		1,749,996	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/23/2023 11:46 am	
		Title XVIII	Subprovider - IRF	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
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY		1,799,890	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.244547	85,993	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.240241	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168573	108,412	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.136926	5,060	59.00
60.00	06000	LABORATORY	0.188223	316,518	60.00
65.00	06500	RESPIRATORY THERAPY	0.181995	284,051	65.00
66.00	06600	PHYSICAL THERAPY	0.731266	1,505,573	66.00
69.00	06900	ELECTROCARDIOLOGY	0.177870	2,901	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.191324	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.525956	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348708	492,093	73.00
74.00	07400	RENAL DIALYSIS	0.942848	19,405	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.656532	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.184911	1,445	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.595234	0	92.00
93.00	04040	FAMILY PRACTICE	0.485269	0	93.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.856119	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,821,451	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		2,821,451	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/23/2023 11:46 am
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		2,113,685		30.00
31.00	03100 INTENSIVE CARE UNIT		369,644		31.00
40.00	04000 SUBPROVIDER - IPF		121,677		40.00
41.00	04100 SUBPROVIDER - IRF		78,875		41.00
43.00	04300 NURSERY		174,282		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.244547	1,020,755	249,623	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.240241	354,313	85,121	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.168573	1,229,289	207,225	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.136926	238,351	32,636	59.00
60.00	06000 LABORATORY	0.188223	1,515,661	285,282	60.00
65.00	06500 RESPIRATORY THERAPY	0.181995	632,315	115,078	65.00
66.00	06600 PHYSICAL THERAPY	0.731266	183,065	133,869	66.00
69.00	06900 ELECTROCARDIOLOGY	0.177870	169,366	30,125	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.191324	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.525956	95,864	50,420	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.348708	1,696,243	591,494	73.00
74.00	07400 RENAL DIALYSIS	0.942848	44,164	41,640	74.00
76.00	03950 ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.656532	0	0	76.97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.184911	931,097	172,170	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.595234	0	0	92.00
93.00	04040 FAMILY PRACTICE	0.485269	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	1.856119	0	0	96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		8,110,483	1,994,683	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)		8,110,483		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/23/2023 11:46 am	
		Title XIX	Subprovider - IPF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF		121,677	40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.244547	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.240241	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168573	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.136926	0	59.00
60.00	06000	LABORATORY	0.188223	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.181995	0	65.00
66.00	06600	PHYSICAL THERAPY	0.731266	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.177870	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.191324	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.525956	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348708	0	73.00
74.00	07400	RENAL DIALYSIS	0.942848	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.656532	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.184911	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.595234	0	92.00
93.00	04040	FAMILY PRACTICE	0.485269	0	93.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.856119	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/23/2023 11:46 am	
		Title XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF		78,875	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.244547	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.240241	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168573	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.136926	0	59.00
60.00	06000	LABORATORY	0.188223	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.181995	0	65.00
66.00	06600	PHYSICAL THERAPY	0.731266	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.177870	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.191324	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.525956	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348708	0	73.00
74.00	07400	RENAL DIALYSIS	0.942848	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.656532	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.184911	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.595234	0	92.00
93.00	04040	FAMILY PRACTICE	0.485269	0	93.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.856119	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/23/2023 11:46 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		35,678,568	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		11,260,280	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)		333,256	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		55,204	2.04
3.00	Managed Care Simulated Payments		19,863,914	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		163.40	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
5.01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)		0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		17.91	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)		0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)		0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)		17.91	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		16.37	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)		16.37	12.00
13.00	Total allowable FTE count for the prior year.		16.44	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.		16.92	14.00
15.00	Sum of lines 12 through 14 divided by 3.		16.58	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		16.58	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.101469	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.099180	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.099180	21.00
22.00	IME payment adjustment (see instructions)		2,473,912	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		1,046,928	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)		-1.54	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)		2,473,912	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		1,046,928	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.22	30.00
31.00	Percentage of Medicaid patient days (see instructions)		25.07	31.00
32.00	Sum of lines 30 and 31		29.29	32.00
33.00	Allowable disproportionate share percentage (see instructions)		13.38	33.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/23/2023 11:46 am	
		Title XVIII	Hospital	PPS	
				1.00	
34.00	Disproportionate share adjustment (see instructions)			1,570,104	34.00
			Prior to 10/1	1.00	
			On/After 10/1	2.00	
Uncompensated Care Payment Adjustment					
35.00	Total uncompensated care amount (see instructions)		7,192,008,710	6,874,403,459	35.00
35.01	Factor 3 (see instructions)		0.000240562	0.000172527	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)		1,730,124	1,186,020	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)		1,294,038	298,942	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		1,592,980		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		52,964,304		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		60,310,350		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			61,357,278	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			3,728,445	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).			586,980	52.00
53.00	Nursing and Allied Health Managed Care payment			165,142	53.00
54.00	Special add-on payments for new technologies			301,702	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
55.01	Cellular therapy acquisition cost (see instructions)			0	55.01
56.00	Cost of physicians' services in a teaching hospital (see 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)			72,634	58.00
59.00	Total (sum of amounts on lines 49 through 58)			66,212,181	59.00
60.00	Primary payer payments			11,184	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			66,200,997	61.00
62.00	Deductibles billed to program beneficiaries			5,014,140	62.00
63.00	Coinurance billed to program beneficiaries			45,513	63.00
64.00	Allowable bad debts (see instructions)			1,025,284	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			666,435	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			561,372	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			61,807,779	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)			0	70.75
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			0	70.93
70.94	HRR adjustment amount (see instructions)			-406,062	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/23/2023 11:46 am	
		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	1.00	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)			485,023	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			60,916,694	71.00
71.01	Sequestration adjustment (see instructions)			767,551	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
71.03	Sequestration adjustment-PARHM or CHART pass-throughs				71.03
72.00	Interim payments			60,192,358	72.00
72.01	Interim payments-PARHM or CHART				72.01
73.00	Tentative settlement (for contractor use only)			0	73.00
73.01	Tentative settlement-PARHM or CHART (for contractor use only)				73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			-43,215	74.00
74.01	Balance due provider/program-PARHM or CHART (see instructions)				74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/23/2023 11:46 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		24,604	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		50,459,279	2.00
3.00	OPPS payments		53,954,132	3.00
4.00	Outlier payment (see instructions)		29,663	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		166,657	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		24,604	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		70,964	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)		70,964	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		70,964	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		46,360	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)		24,604	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)		54,150,452	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)		9,174,219	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)		45,000,837	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		438,132	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)		45,438,969	30.00
31.00	Primary payer payments		17,792	31.00
32.00	Subtotal (line 30 minus line 31)		45,421,177	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)		2,390,808	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		1,554,025	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,768,492	36.00
37.00	Subtotal (see instructions)		46,975,202	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.75	N95 respirator payment adjustment amount (see instructions)		0	39.75
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		46,975,202	40.00
40.01	Sequestration adjustment (see instructions)		591,888	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs			40.03
41.00	Interim payments		45,578,301	41.00
41.01	Interim payments-PARHM or CHART			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		805,013	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/23/2023 11:46 am
		Title XVIII	Hospital PPS
			1.00
200.00	MEDI CARE PART B ANCI LLARY COSTS Part B Combi ned Bi lled Days		0 200.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/23/2023 11:46 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		45	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		975	2.00
3.00	OPPS payments		576	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		3	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		45	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		129	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)		129	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		129	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		84	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)		45	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)		579	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)		93	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)		531	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		531	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		531	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. 1-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		531	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.75	N95 respirator payment adjustment amount (see instructions)		0	39.75
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		531	40.00
40.01	Sequestration adjustment (see instructions)		6	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs			40.03
41.00	Interim payments		523	41.00
41.01	Interim payments-PARHM or CHART			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		2	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/23/2023 11:46 am
	Title XVIII	Subprovider - IPF	PPS
	1.00		
200.00 MEDICARE PART B ANCILLARY COSTS			
200.00 Part B Combined Billed Days			200.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/23/2023 11:46 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		227	2.00
3.00	OPPS payments		219	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		219	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)		0	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)		219	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		219	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		219	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. 1-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		219	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.75	N95 respirator payment adjustment amount (see instructions)		0	39.75
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		219	40.00
40.01	Sequestration adjustment (see instructions)		3	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs			40.03
41.00	Interim payments		215	41.00
41.01	Interim payments-PARHM or CHART			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		1	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/23/2023 11:46 am
	Title XVIII	Subprovider - IRF	PPS
			1.00
200.00 MEDICARE PART B ANCILLARY COSTS	Part B Combined Billed Days		200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0048		Period: From 01/01/2022 To 12/31/2022		Worksheet E-1 Part I Date/Time Prepared: 5/23/2023 11:46 am	
		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		60,146,358		45,578,301	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	04/13/2022	46,000		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)		46,000		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)		60,192,358		45,578,301	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		805,013	6.01	
6.02	SETTLEMENT TO PROGRAM		43,215		0	6.02	
7.00	Total Medicare program liability (see instructions)		60,149,143		46,383,314	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0048
Component CCN: 15-S048

Period:
From 01/01/2022
To 12/31/2022

Worksheet E-1
Part I
Date/Time Prepared:
5/23/2023 11:46 am
PPS

Title XVIII

Subprovider -
IPF

		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					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		1,924,863		523	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)		1,924,863		523	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		63,267		2	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,988,130		525	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0048
Component CCN: 15-T048

Period:
From 01/01/2022
To 12/31/2022

Worksheet E-1
Part I
Date/Time Prepared:
5/23/2023 11:46 am
PPS

Title XVIII

Subprovider -
IRF

		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					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		3,090,758		215	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)		3,090,758		215	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		8,525		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,099,283		216	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet E-1
Part II
Date/Time Prepared:
5/23/2023 11:46 am

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (see instructions)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (see instructions)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPSS & 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: 15-0048 Component CCN: 15-S048	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part II Date/Time Prepared: 5/23/2023 11:46 am
		Title 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)			2,123,361 1.00
2.00	Net IPF PPS Outlier Payments			5,938 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 instructions)			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 instructions)			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)			12.687671 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)			2,129,299 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)			2,129,299 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			2,129,299 18.00
19.00	Deductibles			192,296 19.00
20.00	Subtotal (line 18 minus line 19)			1,937,003 20.00
21.00	Coinsurance			33,454 21.00
22.00	Subtotal (line 20 minus line 21)			1,903,549 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			168,095 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			109,262 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			133,885 25.00
26.00	Subtotal (sum of lines 22 and 24)			2,012,811 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			689 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)			2,013,500 31.00
31.01	Sequestration adjustment (see instructions)			25,370 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			1,924,863 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)			63,267 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			5,938 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: 15-0048 Component CCN: 15-T048	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part III Date/Time Prepared: 5/23/2023 11:46 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			3,017,460 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0091 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			145,140 3.00
4.00	Outlier Payments			19,328 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	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 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			10.438356 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			3,181,928 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			3,181,928 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			3,181,928 19.00
20.00	Deductibles			14,004 20.00
21.00	Subtotal (line 19 minus line 20)			3,167,924 21.00
22.00	Coinurance			38,122 22.00
23.00	Subtotal (line 21 minus line 22)			3,129,802 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			13,285 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			8,635 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			7,653 26.00
27.00	Subtotal (sum of lines 23 and 25)			3,138,437 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			395 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.98	Recovery of accelerated depreciation.			0 31.98
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			3,138,832 32.00
32.01	Sequestration adjustment (see instructions)			39,549 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			3,090,758 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			8,525 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			19,328 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: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/23/2023 11:46 am	
		Title XIX	Hospital	Cost	
			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		3,368,431		1.00
2.00	Medical and other services			3,472,190	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		3,368,431	3,472,190	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)		3,368,431	3,472,190	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		8,110,483	13,666,864	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)		8,110,483	13,666,864	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		8,110,483	13,666,864	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		4,742,052	10,194,674	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		3,368,431	3,472,190	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		3,368,431	3,472,190	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		3,368,431	3,472,190	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		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)		3,368,431	3,472,190	36.00
37.00	ZERO OUT MEDICAID		-3,368,431	-3,472,190	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0		40.00
41.00	Interim payments		0		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: 15-0048 Component CCN: 15-S048	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/23/2023 11:46 am
		Title XIX	Subprovider - IPF	Cost
		Inpatient 1.00	Outpatient 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	251,223		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	251,223	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)	251,223	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	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)	0	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	251,223	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	251,223	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/23/2023 11:46 am	
		Title XIX	Subprovider - IRF	Cost	
			Inpatient 1.00	Outpatient 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 programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	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	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	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)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet E-4 Date/Time Prepared: 5/23/2023 11:46 am	
		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.			0.00	1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)			0.00	1.01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			17.91	2.00
2.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)				2.26
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)				3.02
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
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)				4.21
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27			17.91	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			16.37	6.00
7.00	Enter the lesser of line 5 or line 6			16.37	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.	15.99	0.00	15.99	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. For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.	15.99	0.00	15.99	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	15.99	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	15.85	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	16.42	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	16.09	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	16.09	0.00		17.00
18.00	Per resident amount	104,184.87	104,184.87		18.00
18.01	Per resident amount under §131 of the CAA 2021				18.01
19.00	Approved amount for resident costs	1,676,335	0	1,676,335	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)			1,676,335	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet E-4 Date/Time Prepared: 5/23/2023 11:46 am
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		Title XVIII		Hospital		PPS	
		Inpatient Part A	Managed Care	Total			
		1.00	2.00	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)	20,357	10,418				26.00
27.00	Total Inpatient Days (see instructions)	49,770	49,770				27.00
28.00	Ratio of inpatient days to total inpatient days	0.409021	0.209323				28.00
29.00	Program direct GME amount	685,656	350,895		1,036,551		29.00
29.01	Percent reduction for MA DGME		3.26				29.01
30.00	Reduction for direct GME payments for Medicare Advantage		11,439		11,439		30.00
31.00	Net Program direct GME amount				1,025,112		31.00
				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)				1,296,107		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)				67,847,253		37.00
38.00	Organ acquisition and HSCT acquisition costs (see instructions)				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)				11,184		40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)				67,836,069		41.00
Part B Reasonable Cost							
42.00	Reasonable cost (see instructions)				50,651,790		42.00
43.00	Primary payer payments (see instructions)				17,792		43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)				50,633,998		44.00
45.00	Total reasonable cost (sum of lines 41 and 44)				118,470,067		45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)				0.572601		46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)				0.427399		47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B							
48.00	Total program GME payment (line 31)				1,025,112		48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)				586,980		49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)				438,132		50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet E-5 Date/Time Prepared: 5/23/2023 11:46 am
Title XVIII			PPS	
			1.00	
TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	1.00
2.00	Capital outlier from Wkst. L, Pt. 1, line 2		0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)		0	4.00
5.00	The rate used to calculate the time value of money (see instructions)		0.00	5.00
6.00	Time value of money for operating expenses (see instructions)		0	6.00
7.00	Time value of money for capital related expenses (see instructions)		0	7.00

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

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet G
Date/Time Prepared:
5/23/2023 11:46 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	46,452,761	0	0	0	1.00
2.00	Temporary investments	446,704,772	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	141,322,373	0	0	0	4.00
5.00	Other receivable	614,594,524	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-64,001,749	0	0	0	6.00
7.00	Inventory	8,652,615	0	0	0	7.00
8.00	Prepaid expenses	13,480,721	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	100	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	1,207,206,117	0	0	0	11.00
FIXED ASSETS						
12.00	Land	18,717,396	0	0	0	12.00
13.00	Land improvements	10,883,356	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	344,604,749	0	0	0	15.00
16.00	Accumulated depreciation	-204,653,442	0	0	0	16.00
17.00	Leasehold improvements	13,645,110	0	0	0	17.00
18.00	Accumulated depreciation	-9,239,627	0	0	0	18.00
19.00	Fixed equipment	2,237,098	0	0	0	19.00
20.00	Accumulated depreciation	-2,004,506	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	220,799,729	0	0	0	23.00
24.00	Accumulated depreciation	-161,837,405	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	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)	233,152,458	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	100,168,516	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	100,168,516	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	1,540,527,091	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	30,058,146	0	0	0	37.00
38.00	Salaries, wages, and fees payable	14,262,083	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	12,967,152	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	4,192,382	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	61,479,763	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	322,245,048	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,051,461	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	325,296,509	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	386,776,272	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	1,153,750,819	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	1,153,750,819	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	1,540,527,091	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet G-1

Date/Time Prepared:
5/23/2023 11:46 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		1,167,554,328		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		104,319,928		0		2.00
3.00	Total (sum of line 1 and line 2)		1,271,874,256		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		1,271,874,256		0		11.00
12.00	AMOUNTS INCLUDED ON HOME OFFICE	118,123,437		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)		118,123,437		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,153,750,819		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	AMOUNTS INCLUDED ON HOME OFFICE		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	77,910,974		77,910,974	1.00
2.00	SUBPROVIDER - IPF	5,079,945		5,079,945	2.00
3.00	SUBPROVIDER - IRF	4,230,371		4,230,371	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	87,221,290		87,221,290	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	12,702,527		12,702,527	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	12,702,527		12,702,527	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	99,923,817		99,923,817	17.00
18.00	Ancillary services	300,306,573	664,061,258	964,367,831	18.00
19.00	Outpatient services	33,007,946	89,451,554	122,459,500	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	6,391,594	6,391,594	26.00
27.00	OTHER	5,205,344	2,421,931	7,627,275	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	438,443,680	762,326,337	1,200,770,017	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		359,905,077		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		359,905,077		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0048

Period:
From 01/01/2022
To 12/31/2022

Worksheet G-3

Date/Time Prepared:
5/23/2023 11:46 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,200,770,017	1.00
2.00	Less contractual allowances and discounts on patients' accounts	713,587,132	2.00
3.00	Net patient revenues (line 1 minus line 2)	487,182,885	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	359,905,077	4.00
5.00	Net income from service to patients (line 3 minus line 4)	127,277,808	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	197,061	6.00
7.00	Income from investments	-44,672,849	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	137,804	13.00
14.00	Revenue from meals sold to employees and guests	3,688,927	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	612	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	56,813	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	7,775	21.00
22.00	Rental of hospital space	7,781,364	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	9,844,613	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	-22,957,880	25.00
26.00	Total (line 5 plus line 25)	104,319,928	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)	104,319,928	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0048

Period: From 01/01/2022

Worksheet 0

Hospice CCN: 15-1524

To 12/31/2022

Date/Time Prepared: 5/23/2023 11:46 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI - CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		1,650	1,650	-1,650	0
2.00	CAP REL COSTS-MVBLE EQUIP*		16,095	16,095	0	16,095
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	94,400	94,400	52,501	146,901
4.00	ADMINISTRATIVE & GENERAL*	349,350	54,730	404,080	23,282	427,362
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0
7.00	HOUSEKEEPING*	0	0	0	0	0
8.00	DIETARY*	0	1,377	1,377	0	1,377
9.00	NURSING ADMINISTRATION*	0	0	0	0	0
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0
11.00	MEDICAL RECORDS*	0	0	0	0	0
12.00	STAFF TRANSPORTATION*	0	103,171	103,171	0	103,171
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0
14.00	PHARMACY*	0	96,128	96,128	0	96,128
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0
17.00	PATIENT/RESIDENTIAL CARE SERVICES					
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0
26.00	PHYSICIAN SERVICES**	0	79,775	79,775	0	79,775
27.00	NURSE PRACTITIONER**	0	0	0	0	0
28.00	REGISTERED NURSE**	831,229	0	831,229	567,146	1,398,375
29.00	LPN/LVN**	90,605	0	90,605	15,044	105,649
30.00	PHYSICAL THERAPY**	0	0	0	0	0
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	0	0
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0
35.00	DIETARY COUNSELING**	0	0	0	0	0
36.00	COUNSELING - OTHER**	0	0	0	0	0
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	139,041	0	139,041	80,822	219,863
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0
40.00	IMAGING SERVICES**	0	0	0	0	0
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	190,666	190,666	46,845	237,511
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0
43.00	OUTPATIENT SERVICES**	0	0	0	0	0
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	714,663	714,663	0	714,663
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0
62.00	FUNDRAISING*	0	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0
66.00	RESIDENTIAL CARE*	0	0	0	0	0
67.00	ADVERTISING*	0	0	0	0	0
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0
69.00	THRIFT STORE*	0	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0
100.00	TOTAL	1,410,225	1,352,655	2,762,880	783,990	3,546,870

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0048

Period: From 01/01/2022

Worksheet 0

Hospice CCN: 15-1524

To 12/31/2022

Date/Time Prepared: 5/23/2023 11:46 am

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	16,095	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	146,901	3.00
4.00	ADMINISTRATIVE & GENERAL*	-40,593	386,769	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	1,377	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	103,171	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	96,128	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	79,775	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	1,398,375	28.00
29.00	LPN/LVN**	0	105,649	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	219,863	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	237,511	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	714,663	46.00
NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	-40,593	3,506,277	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE	Provider CCN: 15-0048 Hospice CCN: 15-1524	Period: From 01/01/2022 To 12/31/2022	Worksheet 0-2 Date/Time Prepared: 5/23/2023 11:46 am
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	Hospice I					
	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED					25.00
26.00	PHYSICIAN SERVICES	0	79,775	79,775	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	27.00
28.00	REGISTERED NURSE	831,229	0	831,229	0	28.00
29.00	LPN/LVN	90,605	0	90,605	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	139,041	0	139,041	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	190,666	190,666	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	714,663	714,663	0	46.00
100.00	TOTAL *	1,060,875	985,104	2,045,979	0	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

	ADJUSTMENTS		TOTAL (col. 5 ± col. 6)	
	6.00	7.00		
DI RECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	79,775	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	831,229	28.00
29.00	LPN/LVN	0	90,605	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	139,041	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	190,666	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	714,663	46.00
100.00	TOTAL *	0	2,045,979	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPIRE CARE

Provider CCN: 15-0048

Period: From 01/01/2022

Worksheet 0-3

Hospice CCN: 15-1524

To 12/31/2022

Date/Time Prepared: 5/23/2023 11:46 am

	Hospice I					
	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	0	0	56,658	28.00
29.00	LPN/LVN	0	0	0	1,503	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	0	8,074	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	4,680	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	46.00
100.00	TOTAL *	0	0	0	70,915	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

	ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
	6.00	7.00	
DI RECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	25.00
26.00	PHYSICIAN SERVICES	0	26.00
27.00	NURSE PRACTITIONER	0	27.00
28.00	REGISTERED NURSE	56,658	28.00
29.00	LPN/LVN	1,503	29.00
30.00	PHYSICAL THERAPY	0	30.00
31.00	OCCUPATIONAL THERAPY	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	33.00
34.00	SPIRITUAL COUNSELING	0	34.00
35.00	DIETARY COUNSELING	0	35.00
36.00	COUNSELING - OTHER	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	8,074	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	38.00
39.00	PATIENT TRANSPORTATION	0	39.00
40.00	IMAGING SERVICES	0	40.00
41.00	LABS & DIAGNOSTICS	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	4,680	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	42.50
43.00	OUTPATIENT SERVICES	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	46.00
100.00	TOTAL *	70,915	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL
INPATIENT CARE

Provider CCN: 15-0048

Period: From 01/01/2022

Worksheet 0-4

Hospice CCN: 15-1524

To 12/31/2022

Date/Time Prepared: 5/23/2023 11:46 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI - CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	0	0	510,488	28.00
29.00	LPN/LVN	0	0	0	13,541	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	0	72,748	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	42,165	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	46.00
100.00	TOTAL *	0	0	0	638,942	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DI RECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	510,488	28.00
29.00	LPN/LVN	0	13,541	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	72,748	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	42,165	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	638,942	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 15-0048

Period: From 01/01/2022

Worksheet 0-5

Hospice CCN: 15-1524

To 12/31/2022

Date/Time Prepared: 5/23/2023 11:46 am

Descriptions		Hospice I			
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of col s. 1 + 2)	
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	12,152	12,152	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	16,095	0	16,095	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	146,901	411,534	558,435	3.00
4.00	ADMINISTRATIVE & GENERAL	386,769	1,075,430	1,462,199	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	79,778	79,778	7.00
8.00	DIETARY	1,377	0	1,377	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	71	71	10.00
11.00	MEDICAL RECORDS	0	849	849	11.00
12.00	STAFF TRANSPORTATION	103,171	0	103,171	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	13.00
14.00	PHARMACY	96,128	132,778	228,906	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	74,985	74,985	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	2,045,979	0	2,045,979	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	70,915	0	70,915	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	638,942	0	638,942	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	3,506,277	1,787,577	5,293,854	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0048

Period: From 01/01/2022

Worksheet 0-6

Hospice CCN: 15-1524

To 12/31/2022

Part I
Date/Time Prepared:
5/23/2023 11:46 am

Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
	0	1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIX	12,152	12,152			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	16,095		16,095		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	558,435	0	0	558,435	3.00
4.00	ADMINISTRATIVE & GENERAL	1,462,199	12,152	0	97,086	1,571,437
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0
7.00	HOUSEKEEPING	79,778	0	0	0	79,778
8.00	DIETARY	1,377	0	0	0	1,377
9.00	NURSING ADMINISTRATION	0	0	0	0	0
10.00	ROUTINE MEDICAL SUPPLIES	71	0	0	0	71
11.00	MEDICAL RECORDS	849	0	0	0	849
12.00	STAFF TRANSPORTATION	103,171	0	0	0	103,171
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0
14.00	PHARMACY	228,906	0	0	0	228,906
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0
16.00	OTHER GENERAL SERVICE	0	0	0	0	0
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		74,985
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0
51.00	HOSPICE ROUTINE HOME CARE	2,045,979			276,402	2,322,381
52.00	HOSPICE INPATIENT RESPIRE CARE	70,915	0	1,555	18,476	90,946
53.00	HOSPICE GENERAL INPATIENT CARE	638,942	0	14,540	166,471	819,953
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0
61.00	VOLUNTEER PROGRAM	0	0	0	0	0
62.00	FUNDRAISING	0	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0
66.00	RESIDENTIAL CARE	0	0	0	0	0
67.00	ADVERTISING	0	0	0	0	0
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0
69.00	THRIFT STORE	0	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD	0				0
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0
99.00	NEGATIVE COST CENTER	0	0	0	0	0
100.00	TOTAL	5,293,854	12,152	16,095	558,435	5,293,854

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0048

Period: From 01/01/2022

Worksheet 0-6

Hospice CCN: 15-1524

To 12/31/2022

Part I
Date/Time Prepared:
5/23/2023 11:46 am

Descriptions	Hospice I					
	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
3.00 EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00 ADMINISTRATIVE & GENERAL	1,571,437					4.00
5.00 PLANT OPERATION & MAINTENANCE	0	0				5.00
6.00 LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00 HOUSEKEEPING	33,679	0		113,457		7.00
8.00 DIETARY	581	0		0	1,958	8.00
9.00 NURSING ADMINISTRATION	0	0		0		9.00
10.00 ROUTINE MEDICAL SUPPLIES	30	0		0		10.00
11.00 MEDICAL RECORDS	358	0		0		11.00
12.00 STAFF TRANSPORTATION	43,554	0		0		12.00
13.00 VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00 PHARMACY	96,634	0		0		14.00
15.00 PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00 OTHER GENERAL SERVICE	0	0		0		16.00
17.00 PATIENT/RESIDENTIAL CARE SERVICES	31,655	0		0		17.00
LEVEL OF CARE						
50.00 HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00 HOSPICE ROUTINE HOME CARE	980,406					51.00
52.00 HOSPICE INPATIENT RESPIRE CARE	38,393	0	0	10,963	187	52.00
53.00 HOSPICE GENERAL INPATIENT CARE	346,147	0	0	102,494	1,771	53.00
NONREIMBURSABLE COST CENTERS						
60.00 BEREAVEMENT PROGRAM	0	0		0		60.00
61.00 VOLUNTEER PROGRAM	0	0		0		61.00
62.00 FUNDRAISING	0	0		0		62.00
63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00 PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00 OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00 RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00 ADVERTISING	0	0		0		67.00
68.00 TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00 THIRFT STORE	0	0		0		69.00
70.00 NURSING FACILITY ROOM & BOARD						70.00
71.00 OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00 NEGATIVE COST CENTER	0	0		0	0	99.00
100.00 TOTAL	1,571,437	0	0	113,457	1,958	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0048

Period: From 01/01/2022

Worksheet 0-6

Hospice CCN: 15-1524

To 12/31/2022

Part I
Date/Time Prepared:
5/23/2023 11:46 am

Descriptions	Hospice I					
	NURSING ADMINISTRATIVE	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
	9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00	0					9.00
10.00	0	101				10.00
11.00	0		1,207			11.00
12.00	0			146,725		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						17.00
LEVEL OF CARE						
50.00	0	0	0	146,725	0	50.00
51.00	0	92	1,106	0	0	51.00
52.00	0	1	10	0	0	52.00
53.00	0	8	91	0	0	53.00
NONREIMBURSABLE COST CENTERS						
60.00	0			0	0	60.00
61.00	0			0	0	61.00
62.00	0			0	0	62.00
63.00	0			0	0	63.00
64.00	0			0	0	64.00
65.00	0			0	0	65.00
66.00	0			0	0	66.00
67.00	0			0	0	67.00
68.00	0			0	0	68.00
69.00	0			0	0	69.00
70.00						70.00
71.00	0			0	0	71.00
99.00	0	0	0	0	0	99.00
100.00	0	101	1,207	146,725	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provider CCN: 15-0048	Period: From 01/01/2022	Worksheet 0-6 Part I Date/Time Prepared: 5/23/2023 11:46 am
		Hospice CCN: 15-1524	To 12/31/2022	

Descriptions	Hospice I				TOTAL	
	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00	325,540					14.00
15.00	0	0				15.00
16.00	0		0			16.00
17.00				106,640		17.00
LEVEL OF CARE						
50.00	0	0	0		146,725	50.00
51.00	298,407	0	0		3,602,392	51.00
52.00	2,596	0	0	10,203	153,299	52.00
53.00	24,537	0	0	96,437	1,391,438	53.00
NONREIMBURSABLE COST CENTERS						
60.00	0		0		0	60.00
61.00	0		0		0	61.00
62.00	0		0		0	62.00
63.00	0		0		0	63.00
64.00	0		0		0	64.00
65.00	0		0		0	65.00
66.00	0	0	0	0	0	66.00
67.00	0		0		0	67.00
68.00	0		0		0	68.00
69.00	0		0		0	69.00
70.00	0		0		0	70.00
71.00	0	0	0	0	0	71.00
99.00	0	0	0	0	0	99.00
100.00	325,540	0	0	106,640	5,293,854	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0048

Period: From 01/01/2022

Worksheet 0-6

Hospice CCN: 15-1524

To 12/31/2022

Part II
Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Descriptions		Hospice I				
		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)
		1.00	2.00	3.00	4A	4.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	445				1.00
2.00	CAP REL COSTS-MVBLE EQUIP		445			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	2,143,364		3.00
4.00	ADMINISTRATIVE & GENERAL	445	0	372,632	-1,571,437	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			1,060,875	0	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	43	70,915	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	402	638,942	0	53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	12,152	16,095	558,435		100.00
101.00	UNIT COST MULTIPLIER	27.307865	36.168539	0.260541		101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0048

Period: From 01/01/2022

Worksheet 0-6

Hospice CCN: 15-1524

To 12/31/2022

Part II
Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	445					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		445			7.00
8.00	DIETARY	0		0	1,735		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	43	0	43	166	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	402	0	402	1,569	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)			113,457	1,958	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	254.959551	1.128530	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0048

Period: From 01/01/2022

Worksheet 0-6

Hospice CCN: 15-1524

To 12/31/2022

Part II
Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Descriptions		Hospice I					
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	20,816					10.00
11.00	MEDICAL RECORDS		20,816				11.00
12.00	STAFF TRANSPORTATION			1,000			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	20,816	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	1,000	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	19,081	19,081	0	0	19,081	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	166	166	0	0	166	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,569	1,569	0	0	1,569	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	101	1,207	146,725	0	325,540	100.00
101.00	UNIT COST MULTIPLIER	0.004852	0.057984	146.725000	0.000000	15.638932	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0048

Period: From 01/01/2022

Worksheet 0-6

Hospice CCN: 15-1524

To 12/31/2022

Part II
Date/Time Prepared:
5/23/2023 11:46 am

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT				1.00
2.00	CAP REL COSTS-MVBLE EQUIP				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT				3.00
4.00	ADMINISTRATIVE & GENERAL				4.00
5.00	PLANT OPERATION & MAINTENANCE				5.00
6.00	LAUNDRY & LINEN SERVICE				6.00
7.00	HOUSEKEEPING				7.00
8.00	DIETARY				8.00
9.00	NURSING ADMINISTRATION				9.00
10.00	ROUTINE MEDICAL SUPPLIES				10.00
11.00	MEDICAL RECORDS				11.00
12.00	STAFF TRANSPORTATION				12.00
13.00	VOLUNTEER SERVICE COORDINATION				13.00
14.00	PHARMACY				14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	20,816			15.00
16.00	OTHER GENERAL SERVICE		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			1,735	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		50.00
51.00	HOSPICE ROUTINE HOME CARE	19,081	0		51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	166	0	166	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,569	0	1,569	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0		60.00
61.00	VOLUNTEER PROGRAM		0		61.00
62.00	FUNDRAISING		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0		63.00
64.00	PALLIATIVE CARE PROGRAM		0		64.00
65.00	OTHER PHYSICIAN SERVICES		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING		0		67.00
68.00	TELEHEALTH/TELEMONITORING		0		68.00
69.00	THRIFT STORE		0		69.00
70.00	NURSING FACILITY ROOM & BOARD		0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER				99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	106,640	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	61.463977	101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 15-0048

Period: From 01/01/2022

Worksheet 0-7

Hospice CCN: 15-1524

To 12/31/2022

Date/Time Prepared: 5/23/2023 11:46 am

Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
			HCHC	HRHC	HIRC	
			2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS						
1.00 PHYSICAL THERAPY	66.00	0.731266	0	0	0	1.00
2.00 OCCUPATIONAL THERAPY	67.00					2.00
3.00 SPEECH PATHOLOGY	68.00					3.00
4.00 DRUGS CHARGED TO PATIENTS	73.00	0.348708	0	0	0	4.00
5.00 DURABLE MEDICAL EQUIP-RENTED	96.00	1.856119	0	0	0	5.00
6.00 LABORATORY	60.00	0.188223	0	0	0	6.00
7.00 MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.000000	0	0	0	7.00
8.00 FAMILY PRACTICE	93.00	0.485269	0	0	0	8.00
9.00 RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00 ANCILLARY - OTHER	76.00	0.000000	0	0	0	10.00
10.97 CARDIAC REHABILITATION	76.97	0.656532	0	0	0	10.97
11.00 Totals (sum of lines 1-11)						11.00

Cost Center Descriptions	Charges by LOC (from Provider Records)	Shared Service Costs by LOC				
	HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
	5.00	6.00	7.00	8.00	9.00	
ANCILLARY SERVICE COST CENTERS						
1.00 PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00 OCCUPATIONAL THERAPY						2.00
3.00 SPEECH PATHOLOGY						3.00
4.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	5.00
6.00 LABORATORY	0	0	0	0	0	6.00
7.00 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	7.00
8.00 FAMILY PRACTICE	0	0	0	0	0	8.00
9.00 RADIOLOGY-THERAPEUTIC						9.00
10.00 ANCILLARY - OTHER	0	0	0	0	0	10.00
10.97 CARDIAC REHABILITATION	0	0	0	0	0	10.97
11.00 Totals (sum of lines 1-11)						11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0048

Period: From 01/01/2022

Worksheet 0-8

Hospice CCN: 15-1524

To 12/31/2022

Date/Time Prepared: 5/23/2023 11:46 am

		Hospice I		TOTAL	
		TITLE XVII MEDI CARE	TITLE XIX MEDI CAID		
		1.00	2.00	3.00	
HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			146,725	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)				4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			3,602,392	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			19,081	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			188.79	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	17,310	86		9.00
10.00	Program cost (line 8 times line 9)	3,267,955	16,236		10.00
HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			153,299	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			166	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			923.49	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	150	0		14.00
15.00	Program cost (line 13 times line 14)	138,524	0		15.00
HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			1,391,438	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			1,569	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			886.83	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	1,240	33		19.00
20.00	Program cost (line 18 times line 19)	1,099,669	29,265		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			5,293,854	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			20,816	22.00
23.00	Average cost per diem (line 21 divided by line 22)			254.32	23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III Date/Time Prepared: 5/23/2023 11:46 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		3,544,126	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		36,529	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)		114.42	3.00
4.00	Number of interns & residents (see instructions)		16.58	4.00
5.00	Indirect medical education percentage (see instructions)		4.17	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)		147,790	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		3,728,445	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