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

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0046	Period: From 09/01/2021 To 08/31/2022	Worksheet S Parts I-III Date/Time Prepared: 1/24/2023 4:19 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 1/24/2023 Time: 4:19 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by TERRE HAUTE REGIONAL HOSPITAL (15-0046) for the cost reporting period beginning 09/01/2021 and ending 08/31/2022 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	Korenna Power		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Korenna Power			2
3	Signatory Title	CFO TERRE HAUTE REGIONAL HOSPITAL			3
4	Date	(Dated when report is electronica			4

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	663,776	-66,371	0	-3,005,596	1.00
2.00	Subprovider - IPF	0	5,317	-14		-2,077,753	2.00
3.00	Subprovider - IRF	0	-24,871	0		-102,030	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	644,222	-66,385	0	-5,185,379	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 1/24/2023 4:19 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 3901 HOSPITAL LANE	PO Box:			1.00
2.00	City: TERRE HAUTE	State: IN	Zip Code: 47802	County: VIGO	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	TERRE HAUTE REGIONAL HOSPITAL	150046	45460	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	TERRE HAUTE PSYCHIATRIC UNIT	15S046	45460	4	09/01/1991	N	P	O	4.00
5.00	Subprovider - IRF	TERRE HAUTE REHAB UNIT	15T046	45460	5	09/01/2006	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	09/01/2021	08/31/2022	20.00
21.00	Type of Control (see instructions)	4		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 1/24/2023 4:19 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	477	293	11	128	3,309	79	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.	36	11	18	0	244		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 1/24/2023 4:19 pm

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 1/24/2023 4:19 pm

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

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

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

		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	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	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	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0046	Period: From 09/01/2021 To 08/31/2022	Worksheet S-2 Part I Date/Time Prepared: 1/24/2023 4:19 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 1/24/2023 4:19 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	195,968	0	722,892	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	44H070	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 1/24/2023 4:19 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: HOSPITAL CORP. OF AMERICA	Contractor's Name: PALMETTO	Contractor's Number: 10001	141.00
142.00	Street: ONE PARK PLAZA	PO Box:		142.00
143.00	City: NASHVILLE	State: TN	Zip Code: 37203	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

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 1/24/2023 4:19 pm

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	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	12/08/2022	Y	12/08/2022	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: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 1/24/2023 4:19 pm

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2021	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JAMES	WELLS	41.00
42.00	Enter the employer/company name of the cost report preparer.	HCA		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-372-6585	JAMES.WELLS2@HCAHEALTHCARE.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0046	Period: From 09/01/2021 To 08/31/2022	Worksheet S-2 Part II Date/Time Prepared: 1/24/2023 4:19 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REPORTING MANAGER REIMBURSEMENT		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: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet S-3 Part I Date/Time Prepared: 1/24/2023 4:19 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	134	48,880	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)		134	48,880	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	18	6,570	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	NEONATAL INTENSIVE CARE UNIT	35.00	6	2,190	0.00	0	12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		158	57,640	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	19	6,935		0	16.00
17.00	SUBPROVIDER - IRF	41.00	12	4,380		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						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)		189				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 1/24/2023 4:19 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,500	909	12,888			1.00
2.00	HMO and other (see instructions)	4,069	3,309				2.00
3.00	HMO IPF Subprovider	376	0				3.00
4.00	HMO IRF Subprovider	253	244				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)	4,500	909	12,888			7.00
8.00	INTENSIVE CARE UNIT	1,116	0	3,475			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	NEONATAL INTENSIVE CARE UNIT	0	0	389			12.00
13.00	NURSERY		0	495			13.00
14.00	Total (see instructions)	5,616	909	17,247	0.00	411.20	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	358	0	4,479	0.00	22.00	16.00
17.00	SUBPROVIDER - IRF	1,062	65	2,005	0.00	10.40	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			51			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	443.60	27.00
28.00	Observation Bed Days		251	923			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	79	110			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 1/24/2023 4:19 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
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	1,227	193	3,825	1.00
2.00	HMO and other (see instructions)			777	976		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				12		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	NEONATAL INTENSIVE CARE UNIT						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,227	193	3,825	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	62	550	776	16.00
17.00	SUBPROVIDER - IRF	0.00	0	82	5	135	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet S-3 Part II Date/Time Prepared: 1/24/2023 4:19 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	31,879,342	0	31,879,342	922,704.00	34.55	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,508,852	0	3,508,852	115,705.00	30.33	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		291,051	0	291,051	1,670.00	174.28	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		9,280,420	0	9,280,420	191,528.00	48.45	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,825,408	0	6,825,408			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		844,452	0	844,452			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		1,605,282	0	1,605,282			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet S-3 Part II Date/Time Prepared: 1/24/2023 4:19 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	83,360	0	83,360	2,324.00	35.87	26.00
27.00	Administrative & General	5.00	3,682,397	-77,421	3,604,976	93,052.00	38.74	27.00
28.00	Administrative & General under contract (see inst.)		50,854	0	50,854	183.00	277.89	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	536,965	0	536,965	17,493.00	30.70	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,028,444	0	1,028,444	58,561.00	17.56	32.00
33.00	Housekeeping under contract (see instructions)		81,028	0	81,028	6,124.00	13.23	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		959,071	0	959,071	39,440.00	24.32	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	572,419	77,421	649,840	11,848.00	54.85	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet S-3 Part III Date/Time Prepared: 1/24/2023 4:19 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		32,970,295	0	32,970,295	968,451.00	34.04	1.00
2.00	Excluded area salaries (see instructions)		3,508,852	0	3,508,852	115,705.00	30.33	2.00
3.00	Subtotal salaries (line 1 minus line 2)		29,461,443	0	29,461,443	852,746.00	34.55	3.00
4.00	Subtotal other wages & related costs (see inst.)		9,571,471	0	9,571,471	193,198.00	49.54	4.00
5.00	Subtotal wage-related costs (see inst.)		8,430,690	0	8,430,690	0.00	28.62	5.00
6.00	Total (sum of lines 3 thru 5)		47,463,604	0	47,463,604	1,045,944.00	45.38	6.00
7.00	Total overhead cost (see instructions)		6,994,538	0	6,994,538	229,025.00	30.54	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet S-3 Part IV Date/Time Prepared: 1/24/2023 4:19 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,034,165	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	59,539	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)	0	8.02
8.03	Health Insurance (Purchased)	3,615,577	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	6,789	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	37,889	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)	421,253	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	110,504	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,788,782	17.00
18.00	Medicare Taxes - Employers Portion Only	461,987	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	64,891	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	68,484	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,669,860	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet S-3 Part V Date/Time Prepared: 1/24/2023 4:19 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,356,163	7,669,860	1.00
2.00	Hospital	0	6,825,408	2.00
3.00	SUBPROVIDER - IPF	0	0	3.00
4.00	SUBPROVIDER - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	1,356,163	844,452	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet S-10 | Date/Time Prepared: 1/24/2023 4:19 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.132675	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	24,162,863	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?	N	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	198,550,089	6.00
7.00	Medicaid cost (line 1 times line 6)	26,342,633	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)	2,179,770	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)	2,179,770	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)	22,738,717	745,460	23,484,177	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,016,859	745,460	3,762,319	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)	3,016,859	745,460	3,762,319	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)	3,780,884	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	135,453	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	208,390	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,572,494	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	546,918	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,309,237	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,489,007	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet A | Date/Time Prepared: 1/24/2023 4:19 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,975,048	2,975,048	207,902	3,182,950	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,086,908	3,086,908	844,139	3,931,047	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	83,360	6,400,545	6,483,905	92,110	6,576,015	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,682,397	11,240,024	14,922,421	-342,758	14,579,663	5.00
7.00	00700	OPERATION OF PLANT	536,965	3,157,506	3,694,471	-3,953	3,690,518	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	558,928	558,928	0	558,928	8.00
9.00	00900	HOUSEKEEPING	1,028,444	410,419	1,438,863	-10	1,438,853	9.00
10.00	01000	DIETARY	0	2,009,969	2,009,969	-537,708	1,472,261	10.00
11.00	01100	CAFETERIA	0	0	0	537,622	537,622	11.00
13.00	01300	NURSING ADMINISTRATION	572,419	880,145	1,452,564	47,705	1,500,269	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	784,920	784,920	0	784,920	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,377,234	3,456,874	7,834,108	304,968	8,139,076	30.00
31.00	03100	INTENSIVE CARE UNIT	2,340,033	1,521,642	3,861,675	-184,540	3,677,135	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	410,167	309,067	719,234	-274	718,960	35.00
40.00	04000	SUBPROVIDER - IPF	1,350,330	709,429	2,059,759	-6,485	2,053,274	40.00
41.00	04100	SUBPROVIDER - IRF	802,359	414,227	1,216,586	-39,510	1,177,076	41.00
43.00	04300	NURSERY	130,592	59,393	189,985	0	189,985	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,097,184	7,944,735	11,041,919	-86,844	10,955,075	50.00
51.00	05100	RECOVERY ROOM	283,973	56,422	340,395	0	340,395	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	994,050	161,846	1,155,896	0	1,155,896	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	817,015	732,344	1,549,359	-157,952	1,391,407	54.00
54.01	03630	ULTRA SOUND	153,838	37,601	191,439	-17,885	173,554	54.01
54.02	03440	MAMMOGRAPHY	89,895	17,643	107,538	0	107,538	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	561,139	418,425	979,564	-21,789	957,775	55.00
56.00	05600	RADIOISOTOPE	83,762	606,436	690,198	-27	690,171	56.00
57.00	05700	CT SCAN	459,710	227,659	687,369	-386	686,983	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	166,506	93,424	259,930	0	259,930	58.00
59.00	05900	CARDIAC CATHETERIZATION	475,471	96,710	572,181	-7,581	564,600	59.00
60.00	06000	LABORATORY	1,152,777	2,076,161	3,228,938	-88,936	3,140,002	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	31,024	697,301	728,325	0	728,325	62.00
65.00	06500	RESPIRATORY THERAPY	754,309	593,112	1,347,421	-101,260	1,246,161	65.00
66.00	06600	PHYSICAL THERAPY	935,880	169,288	1,105,168	0	1,105,168	66.00
69.00	06900	ELECTROCARDIOLOGY	410,899	141,291	552,190	0	552,190	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	22,888	14,480	37,368	0	37,368	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	225,887	1,949,719	2,175,606	163,696	2,339,302	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,424,289	3,424,289	8,774	3,433,063	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,315,128	13,056,545	14,371,673	69,313	14,440,986	73.00
74.00	07400	RENAL DIALYSIS	135	529,780	529,915	-1,878	528,037	74.00
76.00	03950	LITHOTRIPSY	0	63,175	63,175	0	63,175	76.00
76.01	03330	ENDOSCOPY	289,983	422,084	712,067	11,965	724,032	76.01
76.02	03040	PRISION CLINIC	188,803	23,623	212,426	0	212,426	76.02
76.03	03050	WOUND CARE	70,851	563,970	634,821	-1,766	633,055	76.03
76.04	03060	OPIC	439,931	75,271	515,202	640	515,842	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,187,841	6,206,538	8,394,379	-687,283	7,707,096	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,523,179	78,374,916	108,898,095	9	108,898,104	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23	23	0	23	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	841,908	150,253	992,161	-9	992,152	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	0	0	194.01
194.02	07952	SITTERS	514,255	40,428	554,683	0	554,683	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	31,879,342	78,565,620	110,444,962	0	110,444,962	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet A | Date/Time Prepared: 1/24/2023 4:19 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	418,848	3,601,798		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-65,963	3,865,084		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-603,380	5,972,635		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,232,125	26,811,788		5.00
7.00	00700	OPERATION OF PLANT	71,974	3,762,492		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	558,928		8.00
9.00	00900	HOUSEKEEPING	1,823	1,440,676		9.00
10.00	01000	DIETARY	0	1,472,261		10.00
11.00	01100	CAFETERIA	-191,314	346,308		11.00
13.00	01300	NURSING ADMINISTRATION	-6,097	1,494,172		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	77,708	862,628		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,655,175	6,483,901		30.00
31.00	03100	INTENSIVE CARE UNIT	3,872	3,681,007		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	-257,847	461,113		35.00
40.00	04000	SUBPROVIDER - IPF	-127,637	1,925,637		40.00
41.00	04100	SUBPROVIDER - IRF	-28,096	1,148,980		41.00
43.00	04300	NURSERY	0	189,985		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-4,042,496	6,912,579		50.00
51.00	05100	RECOVERY ROOM	0	340,395		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,155,896		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,303	1,389,104		54.00
54.01	03630	ULTRA SOUND	0	173,554		54.01
54.02	03440	MAMMOGRAPHY	0	107,538		54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	-2,315	955,460		55.00
56.00	05600	RADIOISOTOPE	0	690,171		56.00
57.00	05700	CT SCAN	0	686,983		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	259,930		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	564,600		59.00
60.00	06000	LABORATORY	0	3,140,002		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	728,325		62.00
65.00	06500	RESPIRATORY THERAPY	-88,250	1,157,911		65.00
66.00	06600	PHYSICAL THERAPY	-35,375	1,069,793		66.00
69.00	06900	ELECTROCARDIOLOGY	-11,596	540,594		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	37,368		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,339,302		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,433,063		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,440,986		73.00
74.00	07400	RENAL DIALYSIS	2,982	531,019		74.00
76.00	03950	LITHOTRIPSY	0	63,175		76.00
76.01	03330	ENDOSCOPY	-144,200	579,832		76.01
76.02	03040	PRISION CLINIC	0	212,426		76.02
76.03	03050	WOUND CARE	-11,596	621,459		76.03
76.04	03060	OPIC	-10,238	505,604		76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-3,902,295	3,804,801		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,623,159	110,521,263		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OCCUPATIONAL MEDICINE	0	992,152		194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0		194.01
194.02	07952	SITTERS	0	554,683		194.02
194.03	07953	UNLICENSED STAFF	0	0		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	1,623,159	112,068,121		200.00

RECLASSIFICATIONS | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet A-6 | Date/Time Prepared: 1/24/2023 4:19 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	150,108		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	834,171		2.00
3.00	ENDOSCOPY	76.01	0	14,999		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
	0		0	999,278		
	B - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00		67,762		1.00
	0		0	67,762		
	C - EXECUTIVE COMP.					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		92,110		1.00
2.00	NURSING ADMINISTRATION	13.00	77,421	5,128		2.00
	0		77,421	97,238		
	D - CAFETERIA					
1.00	CAFETERIA	11.00	0	537,622		1.00
	0		0	537,622		
	E - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	516,140		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
	0		0	516,140		
	F - DRUG					
1.00	DRUGS CHARGED TO PATIENTS	73.00		74,245		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00		2,943		2.00
3.00	RADIOLOGY-THERAPEUTIC	55.00		194		3.00
4.00	LABORATORY	60.00		41		4.00
5.00	OPIC	76.04		640		5.00
6.00	EMERGENCY	91.00		58		6.00
	0		0	78,121		
	G - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		362,548		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		0	362,548		
	H - ER BEDHOLD					
1.00	ADULTS & PEDIATRICS	30.00	300,992	310,456		1.00
2.00	INTENSIVE CARE UNIT	31.00	29,454	30,381		2.00
	0		330,446	340,837		
	I - EQUIPMENT PROPERTY TAX					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,968		1.00
2.00		0.00	0	0		2.00
	0		0	9,968		
500.00	Grand Total: Increases		407,867	3,009,514		500.00

RECLASSIFICATIONS | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet A-6 | Date/Time Prepared: 1/24/2023 4:19 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LEASES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	100,337	10		1.00
2.00	OPERATION OF PLANT	7.00	0	3,953	10		2.00
3.00	HOUSEKEEPING	9.00	0	10	0		3.00
4.00	DIETARY	10.00	0	86	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	34,844	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	305,810	0		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	233,161	0		7.00
8.00	SUBPROVIDER - IPF	40.00	0	6,470	0		8.00
9.00	OPERATING ROOM	50.00	0	29,716	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	157,973	0		10.00
11.00	ULTRA SOUND	54.01	0	17,885	0		11.00
12.00	RADIOLOGY-THERAPEUTIC	55.00	0	19	0		12.00
13.00	LABORATORY	60.00	0	88,977	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	13,518	0		14.00
15.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	588	0		15.00
16.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,605	0		16.00
17.00	EMERGENCY	91.00	0	4,317	0		17.00
18.00	OCCUPATIONAL MEDICINE	194.00	0	9	0		18.00
	0		0	999,278			
	B - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00		67,762	12		1.00
	0		0	67,762			
	C - EXECUTIVE COMP.						
1.00	ADMINISTRATIVE & GENERAL	5.00	77,421	97,238	0		1.00
2.00		0.00	0	0	0		2.00
	0		77,421	97,238			
	D - CAFETERIA						
1.00	DIETARY	10.00	0	537,622	0		1.00
	0		0	537,622			
	E - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	670	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	8,569	0		2.00
3.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	274	0		3.00
4.00	SUBPROVIDER - IPF	40.00	0	15	0		4.00
5.00	SUBPROVIDER - IRF	41.00	0	234	0		5.00
6.00	OPERATING ROOM	50.00	0	35,370	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,922	0		7.00
8.00	RADIOLOGY-THERAPEUTIC	55.00	0	897	0		8.00
9.00	RADIOISOTOPE	56.00	0	27	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	6,787	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	84,855	0		11.00
12.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	353,774	0		12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,327	0		13.00
14.00	RENAL DIALYSIS	74.00	0	1,878	0		14.00
15.00	ENDOSCOPY	76.01	0	3,034	0		15.00
16.00	WOUND CARE	76.03	0	1,766	0		16.00
17.00	EMERGENCY	91.00	0	11,741	0		17.00
	0		0	516,140			
	F - DRUG						
1.00	INTENSIVE CARE UNIT	31.00		2,645	0		1.00
2.00	SUBPROVIDER - IRF	41.00		39,276	0		2.00
3.00	OPERATING ROOM	50.00		18,954	0		3.00
4.00	CT SCAN	57.00		386	0		4.00
5.00	RESPIRATORY THERAPY	65.00		2,887	0		5.00
6.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		13,973	0		6.00
	0		0	78,121			
	G - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00		2,804	0		1.00
2.00	RADIOLOGY-THERAPEUTIC	55.00		21,067	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00		794	0		3.00
4.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		337,883	0		4.00
	0		0	362,548			
	H - ER BEDHOLD						
1.00	EMERGENCY	91.00	330,446	340,837	0		1.00
2.00		0.00	0	0	0		2.00
	0		330,446	340,837			

RECLASSIFICATIONS | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet A-6 | Date/Time Prepared: 1/24/2023 4:19 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	I - EQUIPMENT PROPERTY TAX						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,968	13		1.00
2.00		0.00	0	0	13		2.00
	0		0	9,968			
500.00	Grand Total: Decreases		407,867	3,009,514			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 1/24/2023 4:19 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,262,718	0	0	0	0	1.00
2.00	Land Improvements	3,238,473	0	0	0	0	2.00
3.00	Buildings and Fixtures	38,638,215	0	0	0	0	3.00
4.00	Building Improvements	9,572,776	0	0	0	0	4.00
5.00	Fixed Equipment	31,608,284	0	0	0	0	5.00
6.00	Movable Equipment	53,249,827	3,977,710	0	3,977,710	3,031,407	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	137,570,293	3,977,710	0	3,977,710	3,031,407	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	137,570,293	3,977,710	0	3,977,710	3,031,407	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,262,718	0	1.00
2.00	Land Improvements	3,238,473	0	2.00
3.00	Buildings and Fixtures	38,638,215	0	3.00
4.00	Building Improvements	9,572,776	0	4.00
5.00	Fixed Equipment	31,608,284	0	5.00
6.00	Movable Equipment	54,196,130	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	138,516,596	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	138,516,596	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet A-7 Part II | Date/Time Prepared: 1/24/2023 4:19 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,373,965	4,608	0	0	596,475	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,941,118	145,790	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,315,083	150,398	0	0	596,475	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	2,975,048	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,086,908	2.00
3.00	Total (sum of lines 1-2)	0	6,061,956	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet A-7 Part III Date/Time Prepared: 1/24/2023 4:19 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	84,320,466	0	84,320,466	0.608739	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	54,196,130	0	54,196,130	0.391261	0	2.00
3.00	Total (sum of lines 1-2)	138,516,596	0	138,516,596	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	2,792,813	154,716	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,875,155	979,961	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,667,968	1,134,677	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	67,762	586,507	0	3,601,798	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	9,968	0	3,865,084	2.00
3.00	Total (sum of lines 1-2)	0	67,762	596,475	0	7,466,882	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet A-8 | Date/Time Prepared: 1/24/2023 4:19 pm

	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
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-10,232,788			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	12,443,473			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-178,196	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-13,118	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)	B	-49,659	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	X-RAY COPY	B	-65	RADIOLOGY-DIAGNOSTIC	54.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet A-8 | Date/Time Prepared: 1/24/2023 4:19 pm

	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	
33.01	INTEREST INCOME	B	-16,927	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER REVENUE	B	-59,767	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	HEALTH REFUND	B	-987	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04	UNCLAIMED PROPERTY	B	-3,104	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	PATIENT TELEPHONES	A	-10,137	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.05
33.06	PATIENT TELEPHONES	A	-54,052	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	CONSULTING 900-317	A	-29,179	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	ADMIN. TRAVEL 900-750	A	-7,378	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	ADMIN. MEALS 900-764	A	-23,006	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	MISC. XXX870	A	-125	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	MISC. XXX872	A	-1,335	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	NONPATIENT GIFTS	A	-37,547	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	ALCOHOL	A	-35	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	COUNTRY CLUB DUES	A	-2,260	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	PHYSICIAN RECRUITMENT 906XXX	A	68	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	PHYSICIAN RECRUITMENT XXX802	A	-228	ADMINISTRATIVE & GENERAL	5.00	9	33.16
33.17	PHYSICIAN RECRUITMENT XXX828	A	-20	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	NONALLOWABLES 900805	A	-48	SUBPROVIDER - IPF	40.00	0	33.18
33.19	NONALLOWABLES 900805	A	-14,704	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	CONTRIBUTIONS	A	-4,550	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	MED STAFF NONALLOWABLES 843	A	-98,188	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	PUBLIC RELATIONS DEPT. 920	A	-3,616	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	REHAB ADMPHYS RECR/CY DEPT 950	A	-448	ADMINISTRATIVE & GENERAL	5.00	9	33.23
33.24	SALES DEPT. 965	A	-796	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	LEGAL FEES	A	-1,362	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	LOBBYING DUES	A	-12,849	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	MOB ACCOUNTING	A	-1,306	ADMINISTRATIVE & GENERAL	5.00	0	33.27
33.28	MOB ACCOUNTING	A	-343	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.28
33.29	USEFUL LIFE ADJUSTMENT	A	172,540	CAP REL COSTS-BLDG & FIXT	1.00	9	33.29
33.30	PHYSICIAN RECORDS STORAGE	A	-30	OPERATION OF PLANT	7.00	0	33.30
33.31	DEPRECIATION BUILDING	A	17,344	CAP REL COSTS-BLDG & FIXT	1.00	9	33.31
33.32	DEPRECIATION MME	A	-65,669	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.32
33.33	PATIENT TV'S	A	-294	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.33
33.34	PATIENT TV'S	A	-53,423	OPERATION OF PLANT	7.00	0	33.34
33.35	PATIENT TV'S	A	-2,238	RADIOLOGY-DIAGNOSTIC	54.00	0	33.35
33.36	NONALLOWABLE COSTS	A	-30,489	EMERGENCY	91.00	0	33.36
33.37	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.37
33.38	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.38
33.39	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.39
33.40	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.40
33.41	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.41
33.42	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.42
33.43	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.43
33.44	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.44
33.45	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.45
33.46	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.46
33.47	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.47
33.48	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.48
33.49	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.49
33.50	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.50
33.51	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.51
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,623,159				50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet A-8 | Date/Time Prepared: 1/24/2023 4:19 pm

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) 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: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 1/24/2023 4:19 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HPG	104,308	209,731	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	IT&S	1,584,218	1,929,134	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE COST	1,822,348	4,982,163	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE DIRECT COMP.	149,302	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	SSC	2,318,098	2,193,598	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	SUPPLY CHAIN	1,522,525	1,501,986	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	PARALLON WORKFORCE SOLUTIONS	343,249	342,148	4.03
4.04	7.00	OPERATION OF PLANT	PARALLON WORKFORCE SOLUTIONS	132,705	132,705	4.04
4.05	13.00	NURSING ADMINISTRATION	PARALLON WORKFORCE SOLUTIONS	185,273	184,163	4.05
4.06	30.00	ADULTS & PEDIATRICS	PARALLON WORKFORCE SOLUTIONS	712,982	711,037	4.06
4.07	31.00	INTENSIVE CARE UNIT	PARALLON WORKFORCE SOLUTIONS	792,758	788,886	4.07
4.08	35.00	NEONATAL INTENSIVE CARE UNIT	PARALLON WORKFORCE SOLUTIONS	89,092	88,810	4.08
4.09	40.00	SUBPROVIDER - IPF	PARALLON WORKFORCE SOLUTIONS	261,747	261,312	4.09
4.10	41.00	SUBPROVIDER - IRF	PARALLON WORKFORCE SOLUTIONS	259,041	258,157	4.10
4.11	43.00	NURSERY	PARALLON WORKFORCE SOLUTIONS	7,813	7,813	4.11
4.12	50.00	OPERATING ROOM	PARALLON WORKFORCE SOLUTIONS	122,022	121,468	4.12
4.13	65.00	RESPIRATORY THERAPY	PARALLON WORKFORCE SOLUTIONS	116,710	116,710	4.13
4.14	74.00	RENAL DIALYSIS	PARALLON WORKFORCE SOLUTIONS	520,939	517,957	4.14
4.15	91.00	EMERGENCY	PARALLON WORKFORCE SOLUTIONS	1,696,017	1,689,053	4.15
4.16	5.00	ADMINISTRATIVE & GENERAL	PARALLON WORKFORCE SOLUTIONS	22,266	22,075	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	PARALLON WORKFORCE SOLUTIONS	58,249	58,055	4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	PARALLON WORKFORCE SOLUTIONS	69,360	68,981	4.18
4.19	5.00	ADMINISTRATIVE & GENERAL	PARALLON MARK-UP	0	899,524	4.19
4.20	5.00	ADMINISTRATIVE & GENERAL	PARALLON PAYROLL	20,584	25,410	4.20
4.21	5.00	ADMINISTRATIVE & GENERAL	CAPITAL DIVISION IT&S	977,899	999,272	4.21
4.22	16.00	MEDICAL RECORDS & LIBRARY	HIM	632,903	577,233	4.22
4.23	16.00	MEDICAL RECORDS & LIBRARY	HIM ABSTRACTING	148,132	138,566	4.23
4.24	5.00	ADMINISTRATIVE & GENERAL	REVENUE INTEGRITY	29,740	27,941	4.24
4.25	5.00	ADMINISTRATIVE & GENERAL	CREDENTIALING	63,248	63,459	4.25
4.26	40.00	SUBPROVIDER - IPF	BEHAVIORAL HEALTH	164,810	180,414	4.26
4.27	5.00	ADMINISTRATIVE & GENERAL	IT&S PARALLON	397,135	392,790	4.27
4.28	5.00	ADMINISTRATIVE & GENERAL	PREBILL DENIAL	9,202	8,849	4.28
4.29	4.00	EMPLOYEE BENEFITS DEPARTMENT	HCA HR SERVICES	572,532	572,532	4.29
4.30	4.00	EMPLOYEE BENEFITS DEPARTMENT	NAVIHEALTH FEES	0	-25,860	4.30
4.31	13.00	NURSING ADMINISTRATION	CLINICAL EDUCATION	512,256	519,463	4.31
4.32	16.00	MEDICAL RECORDS & LIBRARY	CANCER REGISTRY-SARAH CANN	81,593	69,121	4.32
4.33	5.00	ADMINISTRATIVE & GENERAL	TRANSFER CTR ALLOCATION	242,975	245,538	4.33
4.34	5.00	ADMINISTRATIVE & GENERAL	URS ALLOCATION	189,443	204,672	4.34
4.35	5.00	ADMINISTRATIVE & GENERAL	CDI MS-DRGRECON TEAM ALLOC	51,041	51,041	4.35
4.36	5.00	ADMINISTRATIVE & GENERAL	SUPPORT SERVICES ALLOCATION	6,631	6,631	4.36
4.37	7.00	OPERATION OF PLANT	FACILITIES MGMT ALLOCATION	20,800	20,800	4.37
4.38	41.00	SUBPROVIDER - IRF	INPAT REHAB ALLOC	39,276	39,276	4.38
4.39	5.00	ADMINISTRATIVE & GENERAL	CALL CENTER	0	57,193	4.39
4.40	5.00	ADMINISTRATIVE & GENERAL	PHYSICIAN RECRUITING	0	62,256	4.40
4.41	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	386,774	722,892	4.41
4.42	5.00	ADMINISTRATIVE & GENERAL	GENERAL LIABILITY INSURANCE	0	22,776	4.42
4.43	5.00	ADMINISTRATIVE & GENERAL	PHYSICIAN SALES	0	188,654	4.43
4.44	5.00	ADMINISTRATIVE & GENERAL	RICHMOND FSC	58,403	62,376	4.44
4.45	4.00	EMPLOYEE BENEFITS DEPARTMENT	RESTORATION PLAN EXP.	0	2,698	4.45
4.46	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INS_POOLING ADJ.	0	615,075	4.46
4.47	5.00	ADMINISTRATIVE & GENERAL	STUDENT LOAN REPAYMENT BENEF	28,196	14,293	4.47
4.48	5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY INTEREST	0	-16,913,508	4.48
4.49	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE INTEREST	571,502	0	4.49
4.50	1.00	CAP REL COSTS-BLDG & FIXT	POB SPACE	39,618	0	4.50
4.51	5.00	ADMINISTRATIVE & GENERAL	POB SPACE	27,448	0	4.51
4.52	7.00	OPERATION OF PLANT	POB SPACE	48,583	0	4.52
4.53	9.00	HOUSEKEEPING	POB SPACE	104	0	4.53
4.54	1.00	CAP REL COSTS-BLDG & FIXT	PAVILLION SPACE	189,346	0	4.54
4.55	5.00	ADMINISTRATIVE & GENERAL	PAVILLION SPACE	1,033	0	4.55
4.56	7.00	OPERATION OF PLANT	PAVILLION SPACE	76,844	0	4.56
4.57	9.00	HOUSEKEEPING	PAVILLION SPACE	1,719	0	4.57
4.58	0.00			0	0	4.58
4.59	0.00			0	0	4.59
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			18,480,792	6,037,319	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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 1/24/2023 4:19 pm

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

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

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

6.00	B		100.00	PARALLON	100.00	6.00
7.00	B		65.02	HPG	65.02	7.00
8.00	B		100.00	HCI	100.00	8.00
9.00	B		100.00	CAPITAL DIVISIO	100.00	9.00
10.00	B		100.00	WORKFORCE MGT.	100.00	10.00
10.01	B		100.00	HCA	100.00	10.01
10.02	B		100.00	POB	100.00	10.02
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: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 1/24/2023 4:19 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-105,423	0		1.00
2.00	-344,916	0		2.00
3.00	-3,159,815	0		3.00
4.00	149,302	0		4.00
4.01	124,500	0		4.01
4.02	20,539	0		4.02
4.03	1,101	0		4.03
4.04	0	0		4.04
4.05	1,110	0		4.05
4.06	1,945	0		4.06
4.07	3,872	0		4.07
4.08	282	0		4.08
4.09	435	0		4.09
4.10	884	0		4.10
4.11	0	0		4.11
4.12	554	0		4.12
4.13	0	0		4.13
4.14	2,982	0		4.14
4.15	6,964	0		4.15
4.16	191	0		4.16
4.17	194	0		4.17
4.18	379	0		4.18
4.19	-899,524	0		4.19
4.20	-4,826	0		4.20
4.21	-21,373	0		4.21
4.22	55,670	0		4.22
4.23	9,566	0		4.23
4.24	1,799	0		4.24
4.25	-211	0		4.25
4.26	-15,604	0		4.26
4.27	4,345	0		4.27
4.28	353	0		4.28
4.29	0	0		4.29
4.30	25,860	0		4.30
4.31	-7,207	0		4.31
4.32	12,472	0		4.32
4.33	-2,563	0		4.33
4.34	-15,229	0		4.34
4.35	0	0		4.35
4.36	0	0		4.36
4.37	0	0		4.37
4.38	0	0		4.38
4.39	-57,193	0		4.39
4.40	-62,256	0		4.40
4.41	-336,118	0		4.41
4.42	-22,776	0		4.42
4.43	-188,654	9		4.43
4.44	-3,973	0		4.44
4.45	-2,698	0		4.45
4.46	-615,075	0		4.46
4.47	13,903	9		4.47
4.48	16,913,508	9		4.48
4.49	571,502	0		4.49
4.50	39,618	9		4.50
4.51	27,448	0		4.51
4.52	48,583	0		4.52
4.53	104	0		4.53
4.54	189,346	9		4.54
4.55	1,033	0		4.55
4.56	76,844	0		4.56
4.57	1,719	0		4.57
4.58	0	0		4.58
4.59	0	0		4.59
5.00	12,443,473			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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0046	Period: From 09/01/2021 To 08/31/2022	Worksheet A-8-1 Date/Time Prepared: 1/24/2023 4:19 pm

	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	MANAGEMENT		6.00
7.00	PURCHASING		7.00
8.00	INSURANCE		8.00
9.00	MANAGEMENT		9.00
10.00	STAFFING		10.00
10.01	HOSPITAL MGT.		10.01
10.02	PROFESSIONAL BU		10.02
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: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 1/24/2023 4:19 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,607,461	1,607,461	0	211,500	0	1.00
2.00	35.00	NEONATAL INTENSIVE CARE UNIT	277,710	229,710	48,000	169,700	240	2.00
3.00	40.00	SUBPROVIDER - IPF	112,420	112,420	0	181,300	0	3.00
4.00	41.00	SUBPROVIDER - IRF	28,980	28,980	0	211,500	0	4.00
5.00	50.00	OPERATING ROOM	4,043,050	4,043,050	0	246,200	0	5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	2,315	2,315	0	271,900	0	6.00
7.00	65.00	RESPIRATORY THERAPY	88,250	88,250	0	211,500	0	7.00
8.00	66.00	PHYSICAL THERAPY	95,063	6,975	88,088	211,500	587	8.00
9.00	69.00	ELECTROCARDIOLOGY	36,000	0	36,000	211,500	240	9.00
10.00	76.01	ENDOSCOPY	144,200	144,200	0	246,400	0	10.00
11.00	76.03	WOUND CARE	36,000	0	36,000	211,500	240	11.00
12.00	76.04	OPIC	22,440	0	22,440	211,500	120	12.00
13.00	91.00	EMERGENCY	3,903,174	3,843,174	60,000	211,500	240	13.00
14.00	5.00	ADMINISTRATIVE & GENERAL	713	190	523	211,500	3	14.00
200.00			10,397,776	10,106,725	291,051		1,670	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	35.00	NEONATAL INTENSIVE CARE UNIT	19,581	979	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	66.00	PHYSICAL THERAPY	59,688	2,984	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	24,404	1,220	0	0	0	9.00
10.00	76.01	ENDOSCOPY	0	0	0	0	0	10.00
11.00	76.03	WOUND CARE	24,404	1,220	0	0	0	11.00
12.00	76.04	OPIC	12,202	610	0	0	0	12.00
13.00	91.00	EMERGENCY	24,404	1,220	0	0	0	13.00
14.00	5.00	ADMINISTRATIVE & GENERAL	305	15	0	0	0	14.00
200.00			164,988	8,248	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,607,461		1.00
2.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	19,581	28,419	258,129		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	112,420		3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	28,980		4.00
5.00	50.00	OPERATING ROOM	0	0	0	4,043,050		5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	2,315		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	88,250		7.00
8.00	66.00	PHYSICAL THERAPY	0	59,688	28,400	35,375		8.00
9.00	69.00	ELECTROCARDIOLOGY	0	24,404	11,596	11,596		9.00
10.00	76.01	ENDOSCOPY	0	0	0	144,200		10.00
11.00	76.03	WOUND CARE	0	24,404	11,596	11,596		11.00
12.00	76.04	OPIC	0	12,202	10,238	10,238		12.00
13.00	91.00	EMERGENCY	0	24,404	35,596	3,878,770		13.00
14.00	5.00	ADMINISTRATIVE & GENERAL	0	305	218	408		14.00
200.00			0	164,988	126,063	10,232,788		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet B Part I | Date/Time Prepared: 1/24/2023 4:19 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,601,798	3,601,798				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,865,084		3,865,084			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,972,635	23,424	25,137	6,021,196		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,811,788	330,727	354,903	682,674	28,180,092	5.00
7.00	00700	OPERATION OF PLANT	3,762,492	935,332	1,003,704	101,685	5,803,213	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	558,928	38,764	41,597	0	639,289	8.00
9.00	00900	HOUSEKEEPING	1,440,676	27,476	29,485	194,756	1,692,393	9.00
10.00	01000	DIETARY	1,472,261	57,739	61,960	0	1,591,960	10.00
11.00	01100	CAFETERIA	346,308	34,853	37,401	0	418,562	11.00
13.00	01300	NURSING ADMINISTRATION	1,494,172	11,665	12,518	123,060	1,641,415	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	862,628	7,462	8,007	0	878,097	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,483,901	560,834	601,830	885,909	8,532,474	30.00
31.00	03100	INTENSIVE CARE UNIT	3,681,007	115,204	123,626	448,710	4,368,547	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	461,113	0	0	77,673	538,786	35.00
40.00	04000	SUBPROVIDER - IPF	1,925,637	99,667	106,952	255,712	2,387,968	40.00
41.00	04100	SUBPROVIDER - IRF	1,148,980	94,293	101,185	151,943	1,496,401	41.00
43.00	04300	NURSERY	189,985	21,592	23,170	24,730	259,477	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,912,579	277,484	297,768	586,514	8,074,345	50.00
51.00	05100	RECOVERY ROOM	340,395	14,961	16,055	53,776	425,187	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,155,896	44,761	48,033	188,243	1,436,933	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,389,104	148,301	159,141	154,718	1,851,264	54.00
54.01	03630	ULTRA SOUND	173,554	12,931	13,876	29,132	229,493	54.01
54.02	03440	MAMMOGRAPHY	107,538	31,462	33,762	17,023	189,785	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	955,460	40,483	43,442	106,263	1,145,648	55.00
56.00	05600	RADIOISOTOPE	690,171	9,134	9,801	15,862	724,968	56.00
57.00	05700	CT SCAN	686,983	17,625	18,913	87,055	810,576	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	259,930	17,559	18,842	31,531	327,862	58.00
59.00	05900	CARDIAC CATHETERIZATION	564,600	21,658	23,241	90,040	699,539	59.00
60.00	06000	LABORATORY	3,140,002	66,637	71,508	218,301	3,496,448	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	728,325	2,956	3,172	5,875	740,328	62.00
65.00	06500	RESPIRATORY THERAPY	1,157,911	17,823	19,126	142,843	1,337,703	65.00
66.00	06600	PHYSICAL THERAPY	1,069,793	68,837	73,869	177,228	1,389,727	66.00
69.00	06900	ELECTROCARDIOLOGY	540,594	41,002	43,999	77,812	703,407	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	37,368	5,034	5,402	4,334	52,138	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,339,302	60,743	65,183	42,776	2,508,004	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,433,063	0	0	0	3,433,063	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,440,986	42,003	45,074	249,046	14,777,109	73.00
74.00	07400	RENAL DIALYSIS	531,019	9,351	10,034	26	550,430	74.00
76.00	03950	LITHOTRIPSY	63,175	0	0	0	63,175	76.00
76.01	03330	ENDOSCOPY	579,832	14,961	16,055	54,914	665,762	76.01
76.02	03040	PRISION CLINIC	212,426	41,862	44,922	35,754	334,964	76.02
76.03	03050	WOUND CARE	621,459	24,180	25,948	13,417	685,004	76.03
76.04	03060	OPIC	505,604	41,843	44,901	83,310	675,658	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,804,801	132,801	142,509	351,735	4,431,846	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	110,521,263	3,565,424	3,826,051	5,764,380	110,189,040	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23	5,346	5,737	0	11,106	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	992,152	31,028	33,296	159,432	1,215,908	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	0	0	194.01
194.02	07952	SITTERS	554,683	0	0	97,384	652,067	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	112,068,121	3,601,798	3,865,084	6,021,196	112,068,121	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet B Part I Date/Time Prepared: 1/24/2023 4:19 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,180,092					5.00
7.00	00700	OPERATION OF PLANT	1,949,444	7,752,657				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	214,753	129,965	984,007			8.00
9.00	00900	HOUSEKEEPING	568,517	92,122	0	2,353,032		9.00
10.00	01000	DIETARY	534,779	193,586	0	60,489	2,380,814	10.00
11.00	01100	CAFETERIA	140,605	116,855	0	36,513	0	11.00
13.00	01300	NURSING ADMINISTRATION	551,392	39,110	0	12,220	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	294,975	25,018	0	7,817	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,866,271	1,880,348	537,432	587,542	1,016,929	30.00
31.00	03100	INTENSIVE CARE UNIT	1,467,504	386,254	143,120	120,690	127,712	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	180,992	0	16,021	0	9,233	35.00
40.00	04000	SUBPROVIDER - IPF	802,178	334,160	184,470	104,413	354,257	40.00
41.00	04100	SUBPROVIDER - IRF	502,679	316,141	82,577	98,783	145,953	41.00
43.00	04300	NURSERY	87,165	72,393	20,387	22,620	1,857	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,712,374	930,340	0	290,698	0	50.00
51.00	05100	RECOVERY ROOM	142,831	50,162	0	15,674	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	482,702	150,074	0	46,893	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	621,886	497,218	0	155,363	0	54.00
54.01	03630	ULTRA SOUND	77,092	43,353	0	13,546	0	54.01
54.02	03440	MAMMOGRAPHY	63,754	105,486	0	32,961	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	384,852	135,729	0	42,410	0	55.00
56.00	05600	RADIOISOTOPE	243,535	30,623	0	9,569	0	56.00
57.00	05700	CT SCAN	272,293	59,092	0	18,464	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	110,137	58,871	0	18,395	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	234,993	72,615	0	22,689	0	59.00
60.00	06000	LABORATORY	1,174,544	223,417	0	69,810	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	248,695	9,912	0	3,097	0	62.00
65.00	06500	RESPIRATORY THERAPY	449,368	59,757	0	18,672	0	65.00
66.00	06600	PHYSICAL THERAPY	466,844	230,796	0	72,115	0	66.00
69.00	06900	ELECTROCARDIOLOGY	236,292	137,470	0	42,955	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17,514	16,879	0	5,274	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	842,501	203,656	0	63,635	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,153,252	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,964,006	140,827	0	44,003	0	73.00
74.00	07400	RENAL DIALYSIS	184,903	31,351	0	9,796	0	74.00
76.00	03950	LITHOTRIPSY	21,222	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	223,646	50,162	0	15,674	0	76.01
76.02	03040	PRISION CLINIC	112,523	140,352	0	43,855	0	76.02
76.03	03050	WOUND CARE	230,110	81,070	0	25,331	0	76.03
76.04	03060	OPIC	226,970	140,289	0	43,835	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,488,768	445,251	0	139,125	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,548,861	7,630,704	984,007	2,314,926	1,655,941	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,731	17,924	0	5,601	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	408,454	104,029	0	32,505	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	0	0	194.01
194.02	07952	SITTERS	219,046	0	0	0	724,873	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	28,180,092	7,752,657	984,007	2,353,032	2,380,814	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet B Part I Date/Time Prepared: 1/24/2023 4:19 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	712,535					11.00
13.00	01300	NURSING ADMINISTRATION	17,390	2,261,527				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,205,907			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	125,201	592,040	30,182	16,168,419	0	30.00
31.00	03100	INTENSIVE CARE UNIT	63,410	472,566	20,705	7,170,508	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	10,976	68,034	2,259	826,301	0	35.00
40.00	04000	SUBPROVIDER - IPF	36,136	153,600	35,141	4,392,323	0	40.00
41.00	04100	SUBPROVIDER - IRF	21,472	143,622	5,377	2,813,005	0	41.00
43.00	04300	NURSERY	3,495	22,013	1,557	490,964	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	82,884	0	154,857	12,245,498	0	50.00
51.00	05100	RECOVERY ROOM	7,599	0	16,345	657,798	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,602	133,244	7,905	2,284,353	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,864	0	20,111	3,167,706	0	54.00
54.01	03630	ULTRA SOUND	4,117	0	6,404	374,005	0	54.01
54.02	03440	MAMMOGRAPHY	2,406	0	3,146	397,538	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	15,017	0	27,512	1,751,168	0	55.00
56.00	05600	RADIOISOTOPE	2,242	0	24,398	1,035,335	0	56.00
57.00	05700	CT SCAN	12,302	0	97,314	1,270,041	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,456	0	16,174	535,895	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	12,724	38,320	40,641	1,121,521	0	59.00
60.00	06000	LABORATORY	30,849	0	112,423	5,107,491	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	830	0	11,106	1,013,968	0	62.00
65.00	06500	RESPIRATORY THERAPY	20,186	22,432	26,329	1,934,447	0	65.00
66.00	06600	PHYSICAL THERAPY	25,045	0	15,152	2,199,679	0	66.00
69.00	06900	ELECTROCARDIOLOGY	10,996	27,459	33,173	1,191,752	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	613	0	1,929	94,347	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,045	0	73,046	3,696,887	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	32,826	4,619,141	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,194	0	239,816	20,200,955	0	73.00
74.00	07400	RENAL DIALYSIS	4	0	1,431	777,915	0	74.00
76.00	03950	LITHOTRIPSY	0	0	1,814	86,211	0	76.00
76.01	03330	ENDOSCOPY	7,760	0	20,565	983,569	0	76.01
76.02	03040	PRISION CLINIC	5,053	0	1,013	637,760	0	76.02
76.03	03050	WOUND CARE	1,896	0	6,956	1,030,367	0	76.03
76.04	03060	OPIC	11,773	56,527	10,395	1,165,447	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	49,706	529,760	107,905	7,192,361	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	676,243	2,259,617	1,205,907	108,634,675	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	38,362	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	22,530	0	0	1,783,426	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	0	0	194.01
194.02	07952	SITTERS	13,762	1,910	0	1,611,658	0	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
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)	712,535	2,261,527	1,205,907	112,068,121	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet B Part I Date/Time Prepared: 1/24/2023 4:19 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	16,168,419		30.00
31.00	03100	INTENSIVE CARE UNIT	7,170,508		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	826,301		35.00
40.00	04000	SUBPROVIDER - IPF	4,392,323		40.00
41.00	04100	SUBPROVIDER - IRF	2,813,005		41.00
43.00	04300	NURSERY	490,964		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	12,245,498		50.00
51.00	05100	RECOVERY ROOM	657,798		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,284,353		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,167,706		54.00
54.01	03630	ULTRA SOUND	374,005		54.01
54.02	03440	MAMMOGRAPHY	397,538		54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,751,168		55.00
56.00	05600	RADIOISOTOPE	1,035,335		56.00
57.00	05700	CT SCAN	1,270,041		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	535,895		58.00
59.00	05900	CARDIAC CATHETERIZATION	1,121,521		59.00
60.00	06000	LABORATORY	5,107,491		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,013,968		62.00
65.00	06500	RESPIRATORY THERAPY	1,934,447		65.00
66.00	06600	PHYSICAL THERAPY	2,199,679		66.00
69.00	06900	ELECTROCARDIOLOGY	1,191,752		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	94,347		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,696,887		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,619,141		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,200,955		73.00
74.00	07400	RENAL DIALYSIS	777,915		74.00
76.00	03950	LITHOTRIPSY	86,211		76.00
76.01	03330	ENDOSCOPY	983,569		76.01
76.02	03040	PRISION CLINIC	637,760		76.02
76.03	03050	WOUND CARE	1,030,367		76.03
76.04	03060	OPIC	1,165,447		76.04
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	7,192,361		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	108,634,675		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	38,362		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07950	OCCUPATIONAL MEDICINE	1,783,426		194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0		194.01
194.02	07952	SITTERS	1,611,658		194.02
194.03	07953	UNLICENSED STAFF	0		194.03
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	112,068,121		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet B Part II | Date/Time Prepared: 1/24/2023 4:19 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	23,424	25,137	48,561	48,561	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,279,197	330,727	354,903	2,964,827	5,505	5.00
7.00	00700	OPERATION OF PLANT	345	935,332	1,003,704	1,939,381	820	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	38,764	41,597	80,361	0	8.00
9.00	00900	HOUSEKEEPING	0	27,476	29,485	56,961	1,570	9.00
10.00	01000	DIETARY	0	57,739	61,960	119,699	0	10.00
11.00	01100	CAFETERIA	0	34,853	37,401	72,254	0	11.00
13.00	01300	NURSING ADMINISTRATION	34,001	11,665	12,518	58,184	992	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,121	7,462	8,007	22,590	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,853	560,834	601,830	1,164,517	7,155	30.00
31.00	03100	INTENSIVE CARE UNIT	2,061	115,204	123,626	240,891	3,618	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	232	0	0	232	626	35.00
40.00	04000	SUBPROVIDER - IPF	1,348	99,667	106,952	207,967	2,062	40.00
41.00	04100	SUBPROVIDER - IRF	830	94,293	101,185	196,308	1,225	41.00
43.00	04300	NURSERY	20	21,592	23,170	44,782	199	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	317	277,484	297,768	575,569	4,729	50.00
51.00	05100	RECOVERY ROOM	0	14,961	16,055	31,016	434	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	44,761	48,033	92,794	1,518	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	148,301	159,141	307,442	1,248	54.00
54.01	03630	ULTRA SOUND	0	12,931	13,876	26,807	235	54.01
54.02	03440	MAMMOGRAPHY	0	31,462	33,762	65,224	137	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	40,483	43,442	83,925	857	55.00
56.00	05600	RADIOISOTOPE	0	9,134	9,801	18,935	128	56.00
57.00	05700	CT SCAN	0	17,625	18,913	36,538	702	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	17,559	18,842	36,401	254	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	21,658	23,241	44,899	726	59.00
60.00	06000	LABORATORY	0	66,637	71,508	138,145	1,760	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	2,956	3,172	6,128	47	62.00
65.00	06500	RESPIRATORY THERAPY	303	17,823	19,126	37,252	1,152	65.00
66.00	06600	PHYSICAL THERAPY	0	68,837	73,869	142,706	1,429	66.00
69.00	06900	ELECTROCARDIOLOGY	0	41,002	43,999	85,001	627	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,034	5,402	10,436	35	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	60,743	65,183	125,926	345	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	42,003	45,074	87,077	2,008	73.00
74.00	07400	RENAL DIALYSIS	1,354	9,351	10,034	20,739	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	14,961	16,055	31,016	443	76.01
76.02	03040	PRISION CLINIC	0	41,862	44,922	86,784	288	76.02
76.03	03050	WOUND CARE	0	24,180	25,948	50,128	108	76.03
76.04	03060	OPIC	0	41,843	44,901	86,744	672	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,410	132,801	142,509	279,720	2,836	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,333,392	3,565,424	3,826,051	9,724,867	46,490	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,346	5,737	11,083	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	0	31,028	33,296	64,324	1,286	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	0	0	194.01
194.02	07952	SITTERS	0	0	0	0	785	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,333,392	3,601,798	3,865,084	9,800,274	48,561	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet B Part II | Date/Time Prepared: 1/24/2023 4:19 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,970,332					5.00
7.00	00700	OPERATION OF PLANT	205,480	2,145,681				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,636	35,970	138,967			8.00
9.00	00900	HOUSEKEEPING	59,924	25,496	0	143,951		9.00
10.00	01000	DIETARY	56,368	53,578	0	3,701	233,346	10.00
11.00	01100	CAFETERIA	14,820	32,342	0	2,234	0	11.00
13.00	01300	NURSING ADMINISTRATION	58,119	10,824	0	748	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	31,092	6,924	0	478	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	302,118	520,420	75,899	35,941	99,670	30.00
31.00	03100	INTENSIVE CARE UNIT	154,682	106,902	20,212	7,383	12,517	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	19,077	0	2,263	0	905	35.00
40.00	04000	SUBPROVIDER - IPF	84,553	92,485	26,052	6,388	34,721	40.00
41.00	04100	SUBPROVIDER - IRF	52,985	87,497	11,662	6,043	14,305	41.00
43.00	04300	NURSERY	9,188	20,036	2,879	1,384	182	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	285,896	257,488	0	17,784	0	50.00
51.00	05100	RECOVERY ROOM	15,055	13,883	0	959	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	50,879	41,536	0	2,869	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,550	137,614	0	9,505	0	54.00
54.01	03630	ULTRA SOUND	8,126	11,999	0	829	0	54.01
54.02	03440	MAMMOGRAPHY	6,720	29,195	0	2,016	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	40,565	37,565	0	2,595	0	55.00
56.00	05600	RADIOISOTOPE	25,670	8,475	0	585	0	56.00
57.00	05700	CT SCAN	28,701	16,355	0	1,130	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11,609	16,293	0	1,125	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	24,769	20,097	0	1,388	0	59.00
60.00	06000	LABORATORY	123,802	61,835	0	4,271	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	26,214	2,743	0	189	0	62.00
65.00	06500	RESPIRATORY THERAPY	47,365	16,539	0	1,142	0	65.00
66.00	06600	PHYSICAL THERAPY	49,207	63,877	0	4,412	0	66.00
69.00	06900	ELECTROCARDIOLOGY	24,906	38,047	0	2,628	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,846	4,672	0	323	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	88,803	56,365	0	3,893	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	121,558	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	523,253	38,976	0	2,692	0	73.00
74.00	07400	RENAL DIALYSIS	19,490	8,677	0	599	0	74.00
76.00	03950	LITHOTRIPSY	2,237	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	23,573	13,883	0	959	0	76.01
76.02	03040	PRISION CLINIC	11,860	38,845	0	2,683	0	76.02
76.03	03050	WOUND CARE	24,255	22,437	0	1,550	0	76.03
76.04	03060	OPIC	23,924	38,827	0	2,682	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	156,923	123,231	0	8,511	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,903,798	2,111,928	138,967	141,619	162,300	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	393	4,961	0	343	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	43,053	28,792	0	1,989	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	0	0	194.01
194.02	07952	SITTERS	23,088	0	0	0	71,046	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,970,332	2,145,681	138,967	143,951	233,346	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet B Part II Date/Time Prepared: 1/24/2023 4:19 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	121,650					11.00
13.00	01300	NURSING ADMINISTRATION	2,969	131,836				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	61,084			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,371	34,511	1,537	2,263,139	0	30.00
31.00	03100	INTENSIVE CARE UNIT	10,826	27,549	1,054	585,634	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,874	3,966	115	29,058	0	35.00
40.00	04000	SUBPROVIDER - IPF	6,170	8,954	1,789	471,141	0	40.00
41.00	04100	SUBPROVIDER - IRF	3,666	8,373	274	382,338	0	41.00
43.00	04300	NURSERY	597	1,283	79	80,609	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,151	0	7,885	1,163,502	0	50.00
51.00	05100	RECOVERY ROOM	1,297	0	832	63,476	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,542	7,768	402	202,308	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,733	0	1,024	526,116	0	54.00
54.01	03630	ULTRA SOUND	703	0	326	49,025	0	54.01
54.02	03440	MAMMOGRAPHY	411	0	160	103,863	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	2,564	0	1,401	169,472	0	55.00
56.00	05600	RADIOISOTOPE	383	0	1,242	55,418	0	56.00
57.00	05700	CT SCAN	2,100	0	4,955	90,481	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	761	0	824	67,267	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,172	2,234	2,069	98,354	0	59.00
60.00	06000	LABORATORY	5,267	0	5,724	340,804	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	142	0	565	36,028	0	62.00
65.00	06500	RESPIRATORY THERAPY	3,446	1,308	1,341	109,545	0	65.00
66.00	06600	PHYSICAL THERAPY	4,276	0	771	266,678	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,877	1,601	1,689	156,376	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	105	0	98	17,515	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,032	0	3,719	280,083	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,671	123,229	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,009	0	11,897	671,912	0	73.00
74.00	07400	RENAL DIALYSIS	1	0	73	49,579	0	74.00
76.00	03950	LITHOTRIPSY	0	0	92	2,329	0	76.00
76.01	03330	ENDOSCOPY	1,325	0	1,047	72,246	0	76.01
76.02	03040	PRISION CLINIC	863	0	52	141,375	0	76.02
76.03	03050	WOUND CARE	324	0	354	99,156	0	76.03
76.04	03060	OPIC	2,010	3,295	529	158,683	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,486	30,883	5,494	616,084	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	115,453	131,725	61,084	9,542,823	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	16,780	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	3,847	0	0	143,291	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	0	0	194.01
194.02	07952	SITTERS	2,350	111	0	97,380	0	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
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)	121,650	131,836	61,084	9,800,274	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet B Part II Date/Time Prepared: 1/24/2023 4:19 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,263,139		30.00
31.00	03100	INTENSIVE CARE UNIT	585,634		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	29,058		35.00
40.00	04000	SUBPROVIDER - IPF	471,141		40.00
41.00	04100	SUBPROVIDER - IRF	382,338		41.00
43.00	04300	NURSERY	80,609		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,163,502		50.00
51.00	05100	RECOVERY ROOM	63,476		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	202,308		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	526,116		54.00
54.01	03630	ULTRA SOUND	49,025		54.01
54.02	03440	MAMMOGRAPHY	103,863		54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	169,472		55.00
56.00	05600	RADIOISOTOPE	55,418		56.00
57.00	05700	CT SCAN	90,481		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	67,267		58.00
59.00	05900	CARDIAC CATHETERIZATION	98,354		59.00
60.00	06000	LABORATORY	340,804		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	36,028		62.00
65.00	06500	RESPIRATORY THERAPY	109,545		65.00
66.00	06600	PHYSICAL THERAPY	266,678		66.00
69.00	06900	ELECTROCARDIOLOGY	156,376		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17,515		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	280,083		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	123,229		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	671,912		73.00
74.00	07400	RENAL DIALYSIS	49,579		74.00
76.00	03950	LITHOTRIPSY	2,329		76.00
76.01	03330	ENDOSCOPY	72,246		76.01
76.02	03040	PRISION CLINIC	141,375		76.02
76.03	03050	WOUND CARE	99,156		76.03
76.04	03060	OPIC	158,683		76.04
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	616,084		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,542,823		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,780		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07950	OCCUPATIONAL MEDICINE	143,291		194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0		194.01
194.02	07952	SITTERS	97,380		194.02
194.03	07953	UNLICENSED STAFF	0		194.03
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	9,800,274		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet B-1 | Date/Time Prepared: 1/24/2023 4:19 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	381,332					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		381,332				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,480	2,480	31,795,982			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	35,015	35,015	3,604,976	-28,180,092	83,888,029	5.00
7.00	00700	OPERATION OF PLANT	99,026	99,026	536,965	0	5,803,213	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,104	4,104	0	0	639,289	8.00
9.00	00900	HOUSEKEEPING	2,909	2,909	1,028,444	0	1,692,393	9.00
10.00	01000	DIETARY	6,113	6,113	0	0	1,591,960	10.00
11.00	01100	CAFETERIA	3,690	3,690	0	0	418,562	11.00
13.00	01300	NURSING ADMINISTRATION	1,235	1,235	649,840	0	1,641,415	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	790	790	0	0	878,097	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	59,377	59,377	4,678,226	0	8,532,474	30.00
31.00	03100	INTENSIVE CARE UNIT	12,197	12,197	2,369,487	0	4,368,547	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	410,167	0	538,786	35.00
40.00	04000	SUBPROVIDER - IPF	10,552	10,552	1,350,330	0	2,387,968	40.00
41.00	04100	SUBPROVIDER - IRF	9,983	9,983	802,359	0	1,496,401	41.00
43.00	04300	NURSERY	2,286	2,286	130,592	0	259,477	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,378	29,378	3,097,184	0	8,074,345	50.00
51.00	05100	RECOVERY ROOM	1,584	1,584	283,973	0	425,187	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,739	4,739	994,050	0	1,436,933	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,701	15,701	817,015	0	1,851,264	54.00
54.01	03630	ULTRA SOUND	1,369	1,369	153,838	0	229,493	54.01
54.02	03440	MAMMOGRAPHY	3,331	3,331	89,895	0	189,785	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	4,286	4,286	561,139	0	1,145,648	55.00
56.00	05600	RADIOISOTOPE	967	967	83,762	0	724,968	56.00
57.00	05700	CT SCAN	1,866	1,866	459,710	0	810,576	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,859	1,859	166,506	0	327,862	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,293	2,293	475,471	0	699,539	59.00
60.00	06000	LABORATORY	7,055	7,055	1,152,777	0	3,496,448	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	313	313	31,024	0	740,328	62.00
65.00	06500	RESPIRATORY THERAPY	1,887	1,887	754,309	0	1,337,703	65.00
66.00	06600	PHYSICAL THERAPY	7,288	7,288	935,880	0	1,389,727	66.00
69.00	06900	ELECTROCARDIOLOGY	4,341	4,341	410,899	0	703,407	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	533	533	22,888	0	52,138	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,431	6,431	225,887	0	2,508,004	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,433,063	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,447	4,447	1,315,128	0	14,777,109	73.00
74.00	07400	RENAL DIALYSIS	990	990	135	0	550,430	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	63,175	76.00
76.01	03330	ENDOSCOPY	1,584	1,584	289,983	0	665,762	76.01
76.02	03040	PRISION CLINIC	4,432	4,432	188,803	0	334,964	76.02
76.03	03050	WOUND CARE	2,560	2,560	70,851	0	685,004	76.03
76.04	03060	OPIC	4,430	4,430	439,931	0	675,658	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	14,060	14,060	1,857,395	0	4,431,846	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	377,481	377,481	30,439,819	-28,180,092	82,008,948	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	566	566	0	0	11,106	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	3,285	3,285	841,908	0	1,215,908	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	0	0	194.01
194.02	07952	SITTERS	0	0	514,255	0	652,067	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,601,798	3,865,084	6,021,196		28,180,092	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.445308	10.135745	0.189370		0.335925	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			48,561		2,970,332	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001527		0.035408	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet B-1 | Date/Time Prepared: 1/24/2023 4:19 pm

	Cost Center Description	CAPITAL RELATED COSTS			Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)			
		1.00	2.00	4.00	5A	5.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet B-1 | Date/Time Prepared: 1/24/2023 4:19 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	244,811					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,104	23,892				8.00
9.00	00900	HOUSEKEEPING	2,909	0	237,798			9.00
10.00	01000	DIETARY	6,113	0	6,113	94,888		10.00
11.00	01100	CAFETERIA	3,690	0	3,690	0	26,625,597	11.00
13.00	01300	NURSING ADMINISTRATION	1,235	0	1,235	0	649,840	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	790	0	790	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	59,377	13,049	59,377	40,530	4,678,226	30.00
31.00	03100	INTENSIVE CARE UNIT	12,197	3,475	12,197	5,090	2,369,487	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	389	0	368	410,167	35.00
40.00	04000	SUBPROVIDER - IPF	10,552	4,479	10,552	14,119	1,350,330	40.00
41.00	04100	SUBPROVIDER - IRF	9,983	2,005	9,983	5,817	802,359	41.00
43.00	04300	NURSERY	2,286	495	2,286	74	130,592	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,378	0	29,378	0	3,097,184	50.00
51.00	05100	RECOVERY ROOM	1,584	0	1,584	0	283,973	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,739	0	4,739	0	994,050	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,701	0	15,701	0	817,015	54.00
54.01	03630	ULTRA SOUND	1,369	0	1,369	0	153,838	54.01
54.02	03440	MAMMOGRAPHY	3,331	0	3,331	0	89,895	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	4,286	0	4,286	0	561,139	55.00
56.00	05600	RADIOISOTOPE	967	0	967	0	83,762	56.00
57.00	05700	CT SCAN	1,866	0	1,866	0	459,710	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,859	0	1,859	0	166,506	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,293	0	2,293	0	475,471	59.00
60.00	06000	LABORATORY	7,055	0	7,055	0	1,152,777	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	313	0	313	0	31,024	62.00
65.00	06500	RESPIRATORY THERAPY	1,887	0	1,887	0	754,309	65.00
66.00	06600	PHYSICAL THERAPY	7,288	0	7,288	0	935,880	66.00
69.00	06900	ELECTROCARDIOLOGY	4,341	0	4,341	0	410,899	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	533	0	533	0	22,888	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,431	0	6,431	0	225,887	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,447	0	4,447	0	1,315,128	73.00
74.00	07400	RENAL DIALYSIS	990	0	990	0	135	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	1,584	0	1,584	0	289,983	76.01
76.02	03040	PRISION CLINIC	4,432	0	4,432	0	188,803	76.02
76.03	03050	WOUND CARE	2,560	0	2,560	0	70,851	76.03
76.04	03060	OPIC	4,430	0	4,430	0	439,931	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	14,060	0	14,060	0	1,857,395	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	240,960	23,892	233,947	65,998	25,269,434	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	566	0	566	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	3,285	0	3,285	0	841,908	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	0	0	194.01
194.02	07952	SITTERS	0	0	0	28,890	514,255	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
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)	7,752,657	984,007	2,353,032	2,380,814	712,535	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	31.667928	41.185627	9.895087	25.090781	0.026761	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,145,681	138,967	143,951	233,346	121,650	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.764643	5.816466	0.605350	2.459173	0.004569	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: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet B-1 | Date/Time Prepared: 1/24/2023 4:19 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION	11,897,611			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	818,802,205		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	3,114,624	20,490,338		30.00
31.00	03100	INTENSIVE CARE UNIT	2,486,119	14,056,205		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	357,921	1,533,590		35.00
40.00	04000	SUBPROVIDER - IPF	808,071	23,856,800		40.00
41.00	04100	SUBPROVIDER - IRF	755,578	3,650,040		41.00
43.00	04300	NURSERY	115,810	1,057,323		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	105,130,203		50.00
51.00	05100	RECOVERY ROOM	0	11,096,405		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	700,981	5,366,531		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,652,767		54.00
54.01	03630	ULTRA SOUND	0	4,347,900		54.01
54.02	03440	MAMMOGRAPHY	0	2,135,898		54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	18,677,302		55.00
56.00	05600	RADIOISOTOPE	0	16,563,163		56.00
57.00	05700	CT SCAN	0	66,065,315		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	10,980,379		58.00
59.00	05900	CARDIAC CATHETERIZATION	201,598	27,590,924		59.00
60.00	06000	LABORATORY	0	76,322,193		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	7,539,943		62.00
65.00	06500	RESPIRATORY THERAPY	118,014	17,874,132		65.00
66.00	06600	PHYSICAL THERAPY	0	10,286,381		66.00
69.00	06900	ELECTROCARDIOLOGY	144,460	22,520,780		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,309,643		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	49,590,220		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,285,232		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	162,935,920		73.00
74.00	07400	RENAL DIALYSIS	0	971,332		74.00
76.00	03950	LITHOTRIPSY	0	1,231,833		76.00
76.01	03330	ENDOSCOPY	0	13,961,034		76.01
76.02	03040	PRISION CLINIC	0	687,956		76.02
76.03	03050	WOUND CARE	0	4,722,165		76.03
76.04	03060	OPIC	297,380	7,057,159		76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	2,787,007	73,255,199		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,887,563	818,802,205		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OCCUPATIONAL MEDICINE	0	0		194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0		194.01
194.02	07952	SITTERS	10,048	0		194.02
194.03	07953	UNLICENSED STAFF	0	0		194.03
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)	2,261,527	1,205,907		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.190082	0.001473		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	131,836	61,084		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.011081	0.000075		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet C Part I Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,168,419		16,168,419	0	16,168,419	30.00
31.00	03100	INTENSIVE CARE UNIT	7,170,508		7,170,508	0	7,170,508	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	826,301		826,301	28,419	854,720	35.00
40.00	04000	SUBPROVIDER - IPF	4,392,323		4,392,323	0	4,392,323	40.00
41.00	04100	SUBPROVIDER - IRF	2,813,005		2,813,005	0	2,813,005	41.00
43.00	04300	NURSERY	490,964		490,964	0	490,964	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,245,498		12,245,498	0	12,245,498	50.00
51.00	05100	RECOVERY ROOM	657,798		657,798	0	657,798	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,284,353		2,284,353	0	2,284,353	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,167,706		3,167,706	0	3,167,706	54.00
54.01	03630	ULTRA SOUND	374,005		374,005	0	374,005	54.01
54.02	03440	MAMMOGRAPHY	397,538		397,538	0	397,538	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,751,168		1,751,168	0	1,751,168	55.00
56.00	05600	RADIOISOTOPE	1,035,335		1,035,335	0	1,035,335	56.00
57.00	05700	CT SCAN	1,270,041		1,270,041	0	1,270,041	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	535,895		535,895	0	535,895	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,121,521		1,121,521	0	1,121,521	59.00
60.00	06000	LABORATORY	5,107,491		5,107,491	0	5,107,491	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,013,968		1,013,968	0	1,013,968	62.00
65.00	06500	RESPIRATORY THERAPY	1,934,447	0	1,934,447	0	1,934,447	65.00
66.00	06600	PHYSICAL THERAPY	2,199,679	0	2,199,679	28,400	2,228,079	66.00
69.00	06900	ELECTROCARDIOLOGY	1,191,752		1,191,752	11,596	1,203,348	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	94,347		94,347	0	94,347	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,696,887		3,696,887	0	3,696,887	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,619,141		4,619,141	0	4,619,141	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,200,955		20,200,955	0	20,200,955	73.00
74.00	07400	RENAL DIALYSIS	777,915		777,915	0	777,915	74.00
76.00	03950	LITHOTRIPSY	86,211		86,211	0	86,211	76.00
76.01	03330	ENDOSCOPY	983,569		983,569	0	983,569	76.01
76.02	03040	PRISION CLINIC	637,760		637,760	0	637,760	76.02
76.03	03050	WOUND CARE	1,030,367		1,030,367	11,596	1,041,963	76.03
76.04	03060	OPIC	1,165,447		1,165,447	10,238	1,175,685	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,192,361		7,192,361	35,596	7,227,957	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,080,547		1,080,547		1,080,547	92.00
200.00		Subtotal (see instructions)	109,715,222	0	109,715,222	125,845	109,841,067	200.00
201.00		Less Observation Beds	1,080,547		1,080,547		1,080,547	201.00
202.00		Total (see instructions)	108,634,675	0	108,634,675	125,845	108,760,520	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet C Part I Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,236,368		19,236,368			30.00
31.00	03100	INTENSIVE CARE UNIT	14,056,205		14,056,205			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,533,590		1,533,590			35.00
40.00	04000	SUBPROVIDER - IPF	23,856,800		23,856,800			40.00
41.00	04100	SUBPROVIDER - IRF	3,650,040		3,650,040			41.00
43.00	04300	NURSERY	1,057,323		1,057,323			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,602,445	54,527,758	105,130,203	0.116479	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,195,059	6,901,346	11,096,405	0.059280	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,243,402	123,129	5,366,531	0.425667	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,931,517	9,721,250	13,652,767	0.232019	0.000000	54.00
54.01	03630	ULTRA SOUND	1,036,370	3,311,530	4,347,900	0.086020	0.000000	54.01
54.02	03440	MAMMOGRAPHY	3,208	2,132,690	2,135,898	0.186122	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	397,745	18,279,557	18,677,302	0.093759	0.000000	55.00
56.00	05600	RADIOISOTOPE	709,055	15,854,108	16,563,163	0.062508	0.000000	56.00
57.00	05700	CT SCAN	20,165,892	45,899,423	66,065,315	0.019224	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,209,544	7,770,835	10,980,379	0.048805	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	15,545,733	12,045,191	27,590,924	0.040648	0.000000	59.00
60.00	06000	LABORATORY	36,863,275	39,458,918	76,322,193	0.066920	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,524,038	2,015,905	7,539,943	0.134480	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	17,205,897	668,235	17,874,132	0.108226	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	10,086,413	199,968	10,286,381	0.213844	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	12,214,746	10,306,034	22,520,780	0.052918	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	569,805	739,838	1,309,643	0.072040	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,709,305	19,880,915	49,590,220	0.074549	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,883,477	11,401,755	22,285,232	0.207274	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	87,832,344	75,103,576	162,935,920	0.123981	0.000000	73.00
74.00	07400	RENAL DIALYSIS	938,329	33,003	971,332	0.800874	0.000000	74.00
76.00	03950	LITHOTRIPSY	38,315	1,193,518	1,231,833	0.069986	0.000000	76.00
76.01	03330	ENDOSCOPY	2,397,589	11,563,445	13,961,034	0.070451	0.000000	76.01
76.02	03040	PRISION CLINIC	981	686,975	687,956	0.927036	0.000000	76.02
76.03	03050	WOUND CARE	34,488	4,687,677	4,722,165	0.218198	0.000000	76.03
76.04	03060	OPIC	30,181	7,026,978	7,057,159	0.165144	0.000000	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	19,647,543	53,607,656	73,255,199	0.098182	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	353,818	900,152	1,253,970	0.861701	0.000000	92.00
200.00		Subtotal (see instructions)	402,760,840	416,041,365	818,802,205			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	402,760,840	416,041,365	818,802,205			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet C Part I Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Hospital | PPS

		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
35.00	02060	NEONATAL INTENSIVE CARE UNIT		35.00
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	0.116479	50.00
51.00	05100	RECOVERY ROOM	0.059280	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.425667	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.232019	54.00
54.01	03630	ULTRA SOUND	0.086020	54.01
54.02	03440	MAMMOGRAPHY	0.186122	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.093759	55.00
56.00	05600	RADIOISOTOPE	0.062508	56.00
57.00	05700	CT SCAN	0.019224	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.048805	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040648	59.00
60.00	06000	LABORATORY	0.066920	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.134480	62.00
65.00	06500	RESPIRATORY THERAPY	0.108226	65.00
66.00	06600	PHYSICAL THERAPY	0.216605	66.00
69.00	06900	ELECTROCARDIOLOGY	0.053433	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.072040	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.074549	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.207274	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123981	73.00
74.00	07400	RENAL DIALYSIS	0.800874	74.00
76.00	03950	LITHOTRIPSY	0.069986	76.00
76.01	03330	ENDOSCOPY	0.070451	76.01
76.02	03040	PRISION CLINIC	0.927036	76.02
76.03	03050	WOUND CARE	0.220654	76.03
76.04	03060	OPIC	0.166595	76.04
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.098668	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.861701	92.00
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: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet C Part I Date/Time Prepared: 1/24/2023 4:19 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,168,419		16,168,419	0	16,168,419	30.00
31.00	03100	INTENSIVE CARE UNIT	7,170,508		7,170,508	0	7,170,508	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	826,301		826,301	28,419	854,720	35.00
40.00	04000	SUBPROVIDER - IPF	4,392,323		4,392,323	0	4,392,323	40.00
41.00	04100	SUBPROVIDER - IRF	2,813,005		2,813,005	0	2,813,005	41.00
43.00	04300	NURSERY	490,964		490,964	0	490,964	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,245,498		12,245,498	0	12,245,498	50.00
51.00	05100	RECOVERY ROOM	657,798		657,798	0	657,798	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,284,353		2,284,353	0	2,284,353	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,167,706		3,167,706	0	3,167,706	54.00
54.01	03630	ULTRA SOUND	374,005		374,005	0	374,005	54.01
54.02	03440	MAMMOGRAPHY	397,538		397,538	0	397,538	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,751,168		1,751,168	0	1,751,168	55.00
56.00	05600	RADIOISOTOPE	1,035,335		1,035,335	0	1,035,335	56.00
57.00	05700	CT SCAN	1,270,041		1,270,041	0	1,270,041	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	535,895		535,895	0	535,895	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,121,521		1,121,521	0	1,121,521	59.00
60.00	06000	LABORATORY	5,107,491		5,107,491	0	5,107,491	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,013,968		1,013,968	0	1,013,968	62.00
65.00	06500	RESPIRATORY THERAPY	1,934,447	0	1,934,447	0	1,934,447	65.00
66.00	06600	PHYSICAL THERAPY	2,199,679	0	2,199,679	28,400	2,228,079	66.00
69.00	06900	ELECTROCARDIOLOGY	1,191,752		1,191,752	11,596	1,203,348	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	94,347		94,347	0	94,347	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,696,887		3,696,887	0	3,696,887	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,619,141		4,619,141	0	4,619,141	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,200,955		20,200,955	0	20,200,955	73.00
74.00	07400	RENAL DIALYSIS	777,915		777,915	0	777,915	74.00
76.00	03950	LITHOTRIPSY	86,211		86,211	0	86,211	76.00
76.01	03330	ENDOSCOPY	983,569		983,569	0	983,569	76.01
76.02	03040	PRISION CLINIC	637,760		637,760	0	637,760	76.02
76.03	03050	WOUND CARE	1,030,367		1,030,367	11,596	1,041,963	76.03
76.04	03060	OPIC	1,165,447		1,165,447	10,238	1,175,685	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,192,361		7,192,361	35,596	7,227,957	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,080,547		1,080,547		1,080,547	92.00
200.00		Subtotal (see instructions)	109,715,222	0	109,715,222	125,845	109,841,067	200.00
201.00		Less Observation Beds	1,080,547		1,080,547		1,080,547	201.00
202.00		Total (see instructions)	108,634,675	0	108,634,675	125,845	108,760,520	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet C Part I Date/Time Prepared: 1/24/2023 4:19 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,236,368		19,236,368			30.00
31.00	03100	INTENSIVE CARE UNIT	14,056,205		14,056,205			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,533,590		1,533,590			35.00
40.00	04000	SUBPROVIDER - IPF	23,856,800		23,856,800			40.00
41.00	04100	SUBPROVIDER - IRF	3,650,040		3,650,040			41.00
43.00	04300	NURSERY	1,057,323		1,057,323			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,602,445	54,527,758	105,130,203	0.116479	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,195,059	6,901,346	11,096,405	0.059280	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,243,402	123,129	5,366,531	0.425667	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,931,517	9,721,250	13,652,767	0.232019	0.000000	54.00
54.01	03630	ULTRA SOUND	1,036,370	3,311,530	4,347,900	0.086020	0.000000	54.01
54.02	03440	MAMMOGRAPHY	3,208	2,132,690	2,135,898	0.186122	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	397,745	18,279,557	18,677,302	0.093759	0.000000	55.00
56.00	05600	RADIOISOTOPE	709,055	15,854,108	16,563,163	0.062508	0.000000	56.00
57.00	05700	CT SCAN	20,165,892	45,899,423	66,065,315	0.019224	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,209,544	7,770,835	10,980,379	0.048805	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	15,545,733	12,045,191	27,590,924	0.040648	0.000000	59.00
60.00	06000	LABORATORY	36,863,275	39,458,918	76,322,193	0.066920	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,524,038	2,015,905	7,539,943	0.134480	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	17,205,897	668,235	17,874,132	0.108226	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	10,086,413	199,968	10,286,381	0.213844	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	12,214,746	10,306,034	22,520,780	0.052918	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	569,805	739,838	1,309,643	0.072040	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,709,305	19,880,915	49,590,220	0.074549	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,883,477	11,401,755	22,285,232	0.207274	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	87,832,344	75,103,576	162,935,920	0.123981	0.000000	73.00
74.00	07400	RENAL DIALYSIS	938,329	33,003	971,332	0.800874	0.000000	74.00
76.00	03950	LITHOTRIPSY	38,315	1,193,518	1,231,833	0.069986	0.000000	76.00
76.01	03330	ENDOSCOPY	2,397,589	11,563,445	13,961,034	0.070451	0.000000	76.01
76.02	03040	PRISION CLINIC	981	686,975	687,956	0.927036	0.000000	76.02
76.03	03050	WOUND CARE	34,488	4,687,677	4,722,165	0.218198	0.000000	76.03
76.04	03060	OPIC	30,181	7,026,978	7,057,159	0.165144	0.000000	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	19,647,543	53,607,656	73,255,199	0.098182	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	353,818	900,152	1,253,970	0.861701	0.000000	92.00
200.00		Subtotal (see instructions)	402,760,840	416,041,365	818,802,205			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	402,760,840	416,041,365	818,802,205			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet C Part I Date/Time Prepared: 1/24/2023 4:19 pm

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
35.00	02060	NEONATAL INTENSIVE CARE UNIT		35.00
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
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	03630	ULTRA SOUND	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
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 PATIENTS	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	LITHOTRIPSY	0.000000	76.00
76.01	03330	ENDOSCOPY	0.000000	76.01
76.02	03040	PRISION CLINIC	0.000000	76.02
76.03	03050	WOUND CARE	0.000000	76.03
76.04	03060	OPIC	0.000000	76.04
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
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: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D Part I Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,263,139	0	2,263,139	13,811	163.86	30.00
31.00	INTENSIVE CARE UNIT	585,634		585,634	3,475	168.53	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	29,058		29,058	389	74.70	35.00
40.00	SUBPROVIDER - IPF	471,141	0	471,141	4,479	105.19	40.00
41.00	SUBPROVIDER - IRF	382,338	0	382,338	2,005	190.69	41.00
43.00	NURSERY	80,609		80,609	495	162.85	43.00
200.00	Total (lines 30 through 199)	3,811,919		3,811,919	24,654		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	4,500	737,370	30.00
31.00	INTENSIVE CARE UNIT	1,116	188,079	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	0	0	35.00
40.00	SUBPROVIDER - IPF	358	37,658	40.00
41.00	SUBPROVIDER - IRF	1,062	202,513	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	7,036	1,165,620	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D Part II Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,163,502	105,130,203	0.011067	16,940,821	187,484	50.00
51.00	05100	RECOVERY ROOM	63,476	11,096,405	0.005720	1,484,916	8,494	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	202,308	5,366,531	0.037698	22,157	835	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	526,116	13,652,767	0.038535	1,378,177	53,108	54.00
54.01	03630	ULTRA SOUND	49,025	4,347,900	0.011276	315,112	3,553	54.01
54.02	03440	MAMMOGRAPHY	103,863	2,135,898	0.048627	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	169,472	18,677,302	0.009074	152,683	1,385	55.00
56.00	05600	RADIOISOTOPE	55,418	16,563,163	0.003346	282,127	944	56.00
57.00	05700	CT SCAN	90,481	66,065,315	0.001370	6,940,973	9,509	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	67,267	10,980,379	0.006126	983,100	6,022	58.00
59.00	05900	CARDIAC CATHETERIZATION	98,354	27,590,924	0.003565	4,867,369	17,352	59.00
60.00	06000	LABORATORY	340,804	76,322,193	0.004465	11,786,741	52,628	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	36,028	7,539,943	0.004778	2,201,298	10,518	62.00
65.00	06500	RESPIRATORY THERAPY	109,545	17,874,132	0.006129	5,372,464	32,928	65.00
66.00	06600	PHYSICAL THERAPY	266,678	10,286,381	0.025925	2,069,552	53,653	66.00
69.00	06900	ELECTROCARDIOLOGY	156,376	22,520,780	0.006944	4,486,793	31,156	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17,515	1,309,643	0.013374	185,254	2,478	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	280,083	49,590,220	0.005648	9,880,459	55,805	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	123,229	22,285,232	0.005530	4,003,339	22,138	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	671,912	162,935,920	0.004124	26,587,778	109,648	73.00
74.00	07400	RENAL DIALYSIS	49,579	971,332	0.051042	416,543	21,261	74.00
76.00	03950	LITHOTRIPSY	2,329	1,231,833	0.001891	0	0	76.00
76.01	03330	ENDOSCOPY	72,246	13,961,034	0.005175	1,006,198	5,207	76.01
76.02	03040	PRISION CLINIC	141,375	687,956	0.205500	0	0	76.02
76.03	03050	WOUND CARE	99,156	4,722,165	0.020998	12,980	273	76.03
76.04	03060	OPIC	158,683	7,057,159	0.022485	8,586	193	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	616,084	73,255,199	0.008410	6,094,887	51,258	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	151,247	1,253,970	0.120615	112,468	13,565	92.00
200.00		Total (lines 50 through 199)	5,882,151	755,411,879		107,592,775	751,395	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D Part III Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	13,811	0.00	4,500	30.00
31.00	03100	INTENSIVE CARE UNIT		0	3,475	0.00	1,116	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	389	0.00	0	35.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,479	0.00	358	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	2,005	0.00	1,062	41.00
43.00	04300	NURSERY		0	495	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	24,654		7,036	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
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	35.00
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: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D Part IV Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
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 PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	0	0	76.03
76.04	03060	OPIC	0	0	0	0	0	76.04
		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	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D Part IV Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	105,130,203	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	11,096,405	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,366,531	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,652,767	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	4,347,900	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	2,135,898	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	18,677,302	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	16,563,163	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	66,065,315	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	10,980,379	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	27,590,924	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	76,322,193	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	7,539,943	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,874,132	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,286,381	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	22,520,780	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,309,643	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	49,590,220	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	22,285,232	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	162,935,920	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	971,332	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	0	0	1,231,833	0.000000	76.00
76.01	03330	ENDOSCOPY	0	0	0	13,961,034	0.000000	76.01
76.02	03040	PRISION CLINIC	0	0	0	687,956	0.000000	76.02
76.03	03050	WOUND CARE	0	0	0	4,722,165	0.000000	76.03
76.04	03060	OPIC	0	0	0	7,057,159	0.000000	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	73,255,199	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,253,970	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	755,411,879		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D Part IV Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	16,940,821	0	12,154,040	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,484,916	0	1,450,962	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	22,157	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,378,177	0	1,613,182	0	54.00
54.01	03630	ULTRA SOUND	0.000000	315,112	0	563,668	0	54.01
54.02	03440	MAMMOGRAPHY	0.000000	0	0	157,161	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	152,683	0	8,175,241	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	282,127	0	5,464,447	0	56.00
57.00	05700	CT SCAN	0.000000	6,940,973	0	9,982,246	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	983,100	0	1,559,831	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	4,867,369	0	5,272,047	0	59.00
60.00	06000	LABORATORY	0.000000	11,786,741	0	5,486,054	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	2,201,298	0	482,521	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	5,372,464	0	101,096	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,069,552	0	6,602	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	4,486,793	0	3,100,903	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	185,254	0	122,658	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	9,880,459	0	5,491,079	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,003,339	0	3,122,359	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	26,587,778	0	26,745,210	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	416,543	0	8,730	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	160,924	0	76.00
76.01	03330	ENDOSCOPY	0.000000	1,006,198	0	2,934,187	0	76.01
76.02	03040	PRISION CLINIC	0.000000	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.000000	12,980	0	1,684,482	0	76.03
76.04	03060	OPIC	0.000000	8,586	0	2,614,818	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	6,094,887	0	7,101,313	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	112,468	0	123,370	0	92.00
200.00		Total (lines 50 through 199)		107,592,775	0	105,679,131	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D Part V Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.116479	12,154,040	0	0	1,415,690	50.00
51.00	05100	RECOVERY ROOM	0.059280	1,450,962	0	0	86,013	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.425667	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.232019	1,613,182	0	0	374,289	54.00
54.01	03630	ULTRA SOUND	0.086020	563,668	0	0	48,487	54.01
54.02	03440	MAMMOGRAPHY	0.186122	157,161	0	0	29,251	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.093759	8,175,241	0	0	766,502	55.00
56.00	05600	RADIOISOTOPE	0.062508	5,464,447	0	0	341,572	56.00
57.00	05700	CT SCAN	0.019224	9,982,246	0	0	191,899	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.048805	1,559,831	0	0	76,128	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040648	5,272,047	0	0	214,298	59.00
60.00	06000	LABORATORY	0.066920	5,486,054	189	0	367,127	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.134480	482,521	0	0	64,889	62.00
65.00	06500	RESPIRATORY THERAPY	0.108226	101,096	0	0	10,941	65.00
66.00	06600	PHYSICAL THERAPY	0.213844	6,602	0	0	1,412	66.00
69.00	06900	ELECTROCARDIOLOGY	0.052918	3,100,903	0	0	164,094	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.072040	122,658	0	0	8,836	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.074549	5,491,079	0	0	409,354	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.207274	3,122,359	0	0	647,184	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123981	26,745,210	0	145,116	3,315,898	73.00
74.00	07400	RENAL DIALYSIS	0.800874	8,730	0	0	6,992	74.00
76.00	03950	LITHOTRIPSY	0.069986	160,924	0	0	11,262	76.00
76.01	03330	ENDOSCOPY	0.070451	2,934,187	0	0	206,716	76.01
76.02	03040	PRISION CLINIC	0.927036	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.218198	1,684,482	0	0	367,551	76.03
76.04	03060	OPIC	0.165144	2,614,818	0	0	431,822	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.098182	7,101,313	0	0	697,221	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.861701	123,370	0	0	106,308	92.00
200.00		Subtotal (see instructions)		105,679,131	189	145,116	10,361,736	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		105,679,131	189	145,116	10,361,736	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D Part V Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
54.02	03440	MAMMOGRAPHY	0	0		54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	13	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
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 PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	17,992		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	LITHOTRIPSY	0	0		76.00
76.01	03330	ENDOSCOPY	0	0		76.01
76.02	03040	PRISION CLINIC	0	0		76.02
76.03	03050	WOUND CARE	0	0		76.03
76.04	03060	OPIC	0	0		76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	13	17,992		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	13	17,992		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D Part II Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,163,502	105,130,203	0.011067	0	0	50.00
51.00	05100	RECOVERY ROOM	63,476	11,096,405	0.005720	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	202,308	5,366,531	0.037698	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	526,116	13,652,767	0.038535	2,906	112	54.00
54.01	03630	ULTRA SOUND	49,025	4,347,900	0.011276	3,208	36	54.01
54.02	03440	MAMMOGRAPHY	103,863	2,135,898	0.048627	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	169,472	18,677,302	0.009074	0	0	55.00
56.00	05600	RADIOISOTOPE	55,418	16,563,163	0.003346	0	0	56.00
57.00	05700	CT SCAN	90,481	66,065,315	0.001370	33,063	45	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	67,267	10,980,379	0.006126	5,798	36	58.00
59.00	05900	CARDIAC CATHETERIZATION	98,354	27,590,924	0.003565	6,996	25	59.00
60.00	06000	LABORATORY	340,804	76,322,193	0.004465	174,892	781	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	36,028	7,539,943	0.004778	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	109,545	17,874,132	0.006129	15,808	97	65.00
66.00	06600	PHYSICAL THERAPY	266,678	10,286,381	0.025925	2,927	76	66.00
69.00	06900	ELECTROCARDIOLOGY	156,376	22,520,780	0.006944	18,830	131	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17,515	1,309,643	0.013374	9,136	122	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	280,083	49,590,220	0.005648	2,312	13	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	123,229	22,285,232	0.005530	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	671,912	162,935,920	0.004124	182,198	751	73.00
74.00	07400	RENAL DIALYSIS	49,579	971,332	0.051042	0	0	74.00
76.00	03950	LITHOTRIPSY	2,329	1,231,833	0.001891	0	0	76.00
76.01	03330	ENDOSCOPY	72,246	13,961,034	0.005175	0	0	76.01
76.02	03040	PRISION CLINIC	141,375	687,956	0.205500	0	0	76.02
76.03	03050	WOUND CARE	99,156	4,722,165	0.020998	0	0	76.03
76.04	03060	OPIC	158,683	7,057,159	0.022485	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	616,084	73,255,199	0.008410	138,172	1,162	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,253,970	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	5,730,904	755,411,879		596,246	3,387	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D Part IV Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
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 PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	0	0	76.03
76.04	03060	OPIC	0	0	0	0	0	76.04
		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	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D Part IV | Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	105,130,203	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	11,096,405	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,366,531	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,652,767	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	4,347,900	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	2,135,898	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	18,677,302	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	16,563,163	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	66,065,315	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	10,980,379	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	27,590,924	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	76,322,193	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	7,539,943	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,874,132	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,286,381	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	22,520,780	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,309,643	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	49,590,220	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	22,285,232	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	162,935,920	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	971,332	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	0	0	1,231,833	0.000000	76.00
76.01	03330	ENDOSCOPY	0	0	0	13,961,034	0.000000	76.01
76.02	03040	PRISION CLINIC	0	0	0	687,956	0.000000	76.02
76.03	03050	WOUND CARE	0	0	0	4,722,165	0.000000	76.03
76.04	03060	OPIC	0	0	0	7,057,159	0.000000	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	73,255,199	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,253,970	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	755,411,879		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D Part IV | Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,906	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	3,208	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.000000	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	33,063	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	5,798	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	6,996	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	174,892	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	15,808	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,927	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	18,830	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	9,136	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,312	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	182,198	0	468	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0.000000	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0.000000	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.000000	0	0	0	0	76.03
76.04	03060	OPIC	0.000000	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	138,172	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		596,246	0	468	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D Part V | Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.116479	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.059280	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.425667	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.232019	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.086020	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.186122	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.093759	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.062508	0	0	0	0	56.00
57.00	05700	CT SCAN	0.019224	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.048805	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040648	0	0	0	0	59.00
60.00	06000	LABORATORY	0.066920	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.134480	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.108226	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.213844	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.052918	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.072040	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.074549	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.207274	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123981	468	0	192	58	73.00
74.00	07400	RENAL DIALYSIS	0.800874	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.069986	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0.070451	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0.927036	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.218198	0	0	0	0	76.03
76.04	03060	OPIC	0.165144	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.098182	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.861701	0	0	0	0	92.00
200.00		Subtotal (see instructions)		468	0	192	58	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	192	58	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D Part V | Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
54.02	03440	MAMMOGRAPHY	0	0		54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
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 PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	LITHOTRIPSY	0	0		76.00
76.01	03330	ENDOSCOPY	0	0		76.01
76.02	03040	PRISION CLINIC	0	0		76.02
76.03	03050	WOUND CARE	0	0		76.03
76.04	03060	OPIC	0	0		76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	24		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		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D Part II Date/Time Prepared: 1/24/2023 4:19 pm

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	1,163,502	105,130,203	0.011067	77,404	857	50.00
51.00	05100	RECOVERY ROOM	63,476	11,096,405	0.005720	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	202,308	5,366,531	0.037698	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	526,116	13,652,767	0.038535	273,645	10,545	54.00
54.01	03630	ULTRA SOUND	49,025	4,347,900	0.011276	88,129	994	54.01
54.02	03440	MAMMOGRAPHY	103,863	2,135,898	0.048627	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	169,472	18,677,302	0.009074	0	0	55.00
56.00	05600	RADIOISOTOPE	55,418	16,563,163	0.003346	4,713	16	56.00
57.00	05700	CT SCAN	90,481	66,065,315	0.001370	180,338	247	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	67,267	10,980,379	0.006126	39,977	245	58.00
59.00	05900	CARDIAC CATHETERIZATION	98,354	27,590,924	0.003565	40,068	143	59.00
60.00	06000	LABORATORY	340,804	76,322,193	0.004465	620,766	2,772	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	36,028	7,539,943	0.004778	44,479	213	62.00
65.00	06500	RESPIRATORY THERAPY	109,545	17,874,132	0.006129	59,996	368	65.00
66.00	06600	PHYSICAL THERAPY	266,678	10,286,381	0.025925	2,629,115	68,160	66.00
69.00	06900	ELECTROCARDIOLOGY	156,376	22,520,780	0.006944	13,160	91	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17,515	1,309,643	0.013374	26,730	357	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	280,083	49,590,220	0.005648	243,830	1,377	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	123,229	22,285,232	0.005530	76,826	425	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	671,912	162,935,920	0.004124	1,756,095	7,242	73.00
74.00	07400	RENAL DIALYSIS	49,579	971,332	0.051042	64,408	3,288	74.00
76.00	03950	LITHOTRIPSY	2,329	1,231,833	0.001891	0	0	76.00
76.01	03330	ENDOSCOPY	72,246	13,961,034	0.005175	0	0	76.01
76.02	03040	PRISION CLINIC	141,375	687,956	0.205500	0	0	76.02
76.03	03050	WOUND CARE	99,156	4,722,165	0.020998	0	0	76.03
76.04	03060	OPIC	158,683	7,057,159	0.022485	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	616,084	73,255,199	0.008410	5,197	44	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,253,970	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	5,730,904	755,411,879		6,244,876	97,384	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D Part IV Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
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 PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	0	0	76.03
76.04	03060	OPIC	0	0	0	0	0	76.04
		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	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D Part IV Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	105,130,203	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	11,096,405	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,366,531	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,652,767	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	4,347,900	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	2,135,898	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	18,677,302	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	16,563,163	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	66,065,315	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	10,980,379	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	27,590,924	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	76,322,193	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	7,539,943	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,874,132	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,286,381	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	22,520,780	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,309,643	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	49,590,220	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	22,285,232	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	162,935,920	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	971,332	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	0	0	1,231,833	0.000000	76.00
76.01	03330	ENDOSCOPY	0	0	0	13,961,034	0.000000	76.01
76.02	03040	PRISION CLINIC	0	0	0	687,956	0.000000	76.02
76.03	03050	WOUND CARE	0	0	0	4,722,165	0.000000	76.03
76.04	03060	OPIC	0	0	0	7,057,159	0.000000	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	73,255,199	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,253,970	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	755,411,879		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D Part IV | Date/Time Prepared: 1/24/2023 4:19 pm

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	77,404	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	273,645	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	88,129	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.000000	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	4,713	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	180,338	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	39,977	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	40,068	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	620,766	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	44,479	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	59,996	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,629,115	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	13,160	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	26,730	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	243,830	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	76,826	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,756,095	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	64,408	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0.000000	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0.000000	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.000000	0	0	0	0	76.03
76.04	03060	OPIC	0.000000	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	5,197	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		6,244,876	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D Part V Date/Time Prepared: 1/24/2023 4:19 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.116479	0	0	12,718,677	0	50.00
51.00	05100	RECOVERY ROOM	0.059280	0	0	1,713,403	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.425667	0	0	62,089	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.232019	0	0	2,920,442	0	54.00
54.01	03630	ULTRA SOUND	0.086020	0	0	1,085,164	0	54.01
54.02	03440	MAMMOGRAPHY	0.186122	0	0	184,760	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.093759	0	0	1,560,924	0	55.00
56.00	05600	RADIOISOTOPE	0.062508	0	0	2,039,978	0	56.00
57.00	05700	CT SCAN	0.019224	0	0	13,246,918	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.048805	0	0	1,368,543	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040648	0	0	1,503,792	0	59.00
60.00	06000	LABORATORY	0.066920	0	0	12,811,566	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.134480	0	0	291,489	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.108226	0	0	218,012	0	65.00
66.00	06600	PHYSICAL THERAPY	0.213844	0	0	36,489	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.052918	0	0	2,019,950	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.072040	0	0	306,895	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.074549	0	0	3,994,757	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.207274	0	0	1,814,338	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123981	0	0	12,061,678	0	73.00
74.00	07400	RENAL DIALYSIS	0.800874	0	0	2,121	0	74.00
76.00	03950	LITHOTRIPSY	0.069986	0	0	116,861	0	76.00
76.01	03330	ENDOSCOPY	0.070451	0	0	1,671,009	0	76.01
76.02	03040	PRISION CLINIC	0.927036	0	0	16,647	0	76.02
76.03	03050	WOUND CARE	0.218198	0	0	1,400,428	0	76.03
76.04	03060	OPIC	0.165144	0	0	620,300	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.098182	0	0	23,236,074	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.861701	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	99,023,304	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	99,023,304	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D Part V Date/Time Prepared: 1/24/2023 4:19 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,481,459		50.00
51.00	05100	RECOVERY ROOM	0	101,571		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	26,429		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	677,598		54.00
54.01	03630	ULTRA SOUND	0	93,346		54.01
54.02	03440	MAMMOGRAPHY	0	34,388		54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	146,351		55.00
56.00	05600	RADIOISOTOPE	0	127,515		56.00
57.00	05700	CT SCAN	0	254,659		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	66,792		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	61,126		59.00
60.00	06000	LABORATORY	0	857,350		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	39,199		62.00
65.00	06500	RESPIRATORY THERAPY	0	23,595		65.00
66.00	06600	PHYSICAL THERAPY	0	7,803		66.00
69.00	06900	ELECTROCARDIOLOGY	0	106,892		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	22,109		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	297,805		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	376,065		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,495,419		73.00
74.00	07400	RENAL DIALYSIS	0	1,699		74.00
76.00	03950	LITHOTRIPSY	0	8,179		76.00
76.01	03330	ENDOSCOPY	0	117,724		76.01
76.02	03040	PRISION CLINIC	0	15,432		76.02
76.03	03050	WOUND CARE	0	305,571		76.03
76.04	03060	OPIC	0	102,439		76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	2,281,364		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	9,129,879		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	9,129,879		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D-1 | Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	13,811	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,811	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)	12,888	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)	4,500	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)	16,168,419	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)	16,168,419	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)	16,168,419	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)	1,170.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,268,105	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)	5,268,105	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D-1 | Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,170,508	3,475	2,063.46	1,116	2,302,821	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	NEONATAL INTENSIVE CARE UNIT	854,720	389	2,197.22	0	0	47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	11,166,202	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	18,737,128	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)	925,449	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	751,395	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,676,844	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	17,060,284	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	923	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,170.69	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,080,547	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D-1 | Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Hospital | PPS

	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	2,263,139	16,168,419	0.139973	1,080,547	151,247	90.00
91.00	Nursing Program cost	0	16,168,419	0.000000	1,080,547	0	91.00
92.00	Allied health cost	0	16,168,419	0.000000	1,080,547	0	92.00
93.00	All other Medical Education	0	16,168,419	0.000000	1,080,547	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2021 To 08/31/2022	Worksheet D-1 Date/Time Prepared: 1/24/2023 4:19 pm
	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)	4,479	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,479	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)	4,479	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)	358	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)	4,392,323	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)	4,392,323	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)	4,392,323	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)	980.65	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	351,073	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)	351,073	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D-1 | Date/Time Prepared: 1/24/2023 4:19 pm

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	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	54,260	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	405,333	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)	37,658	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	3,387	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	41,045	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	364,288	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046
Component CCN: 15-S046

Period:
From 09/01/2021
To 08/31/2022

Worksheet D-1
Date/Time Prepared:
1/24/2023 4:19 pm

Title XVIII

Subprovider - IPF

PPS

	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	471,141	4,392,323	0.107265	0	0	90.00
91.00	Nursing Program cost	0	4,392,323	0.000000	0	0	91.00
92.00	Allied health cost	0	4,392,323	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,392,323	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2021 To 08/31/2022	Worksheet D-1 Date/Time Prepared: 1/24/2023 4:19 pm
	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)	2,005	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,005	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)	2,005	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)	1,062	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)	2,813,005	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)	2,813,005	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)	2,813,005	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)	1,403.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,489,986	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)	1,489,986	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D-1 | Date/Time Prepared: 1/24/2023 4:19 pm

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	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,017,474	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,507,460	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)	202,513	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	97,384	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	299,897	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,207,563	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046
Component CCN: 15-T046

Period:
From 09/01/2021
To 08/31/2022

Worksheet D-1
Date/Time Prepared:
1/24/2023 4:19 pm

Title XVIII | Subprovider - IRF | PPS

	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	382,338	2,813,005	0.135918	0	0	90.00
91.00	Nursing Program cost	0	2,813,005	0.000000	0	0	91.00
92.00	Allied health cost	0	2,813,005	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,813,005	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D-1 | Date/Time Prepared: 1/24/2023 4:19 pm

Title XIX | Hospital | 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)	13,811	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,811	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)	12,888	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)	909	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)	495	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)	16,168,419	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)	16,168,419	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)	16,168,419	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)	1,170.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,064,157	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)	1,064,157	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D-1 | Date/Time Prepared: 1/24/2023 4:19 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	490,964	495	991.85	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,170,508	3,475	2,063.46	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	NEONATAL INTENSIVE CARE UNIT	826,301	389	2,124.17	0	0	47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	8,000,644	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	9,064,801	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
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	923	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,170.69	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,080,547	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D-1 | Date/Time Prepared: 1/24/2023 4:19 pm

Title XIX | Hospital | Cost

	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	2,263,139	16,168,419	0.139973	1,080,547	151,247	90.00
91.00	Nursing Program cost	0	16,168,419	0.000000	1,080,547	0	91.00
92.00	Allied health cost	0	16,168,419	0.000000	1,080,547	0	92.00
93.00	All other Medical Education	0	16,168,419	0.000000	1,080,547	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2021 To 08/31/2022	Worksheet D-1 Date/Time Prepared: 1/24/2023 4:19 pm
	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)	4,479	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,479	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)	4,479	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)	495	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)	4,392,323	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)	4,392,323	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)	4,392,323	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)	980.65	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: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D-1 | Date/Time Prepared: 1/24/2023 4:19 pm

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	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	417,444	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	417,444	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
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D-1 | Date/Time Prepared: 1/24/2023 4:19 pm

Title XIX | Subprovider - IPF | Cost

	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	471,141	4,392,323	0.107265	0	0	90.00
91.00	Nursing Program cost	0	4,392,323	0.000000	0	0	91.00
92.00	Allied health cost	0	4,392,323	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,392,323	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2021 To 08/31/2022	Worksheet D-1 Date/Time Prepared: 1/24/2023 4:19 pm
	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)	2,005	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,005	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)	2,005	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)	65	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)	495	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)	2,813,005	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)	2,813,005	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)	2,813,005	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)	1,403.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	91,195	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)	91,195	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D-1 | Date/Time Prepared: 1/24/2023 4:19 pm

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	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	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	293,780	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	384,975	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
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046
Component CCN: 15-T046

Period:
From 09/01/2021
To 08/31/2022

Worksheet D-1
Date/Time Prepared:
1/24/2023 4:19 pm

Title XIX | Subprovider - IRF | Cost

	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	382,338	2,813,005	0.135918	0	0	90.00
91.00	Nursing Program cost	0	2,813,005	0.000000	0	0	91.00
92.00	Allied health cost	0	2,813,005	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,813,005	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D-3 | Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		6,510,274		30.00
31.00	03100	INTENSIVE CARE UNIT		4,603,489		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0		35.00
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	0.116479	16,940,821	1,973,250	50.00
51.00	05100	RECOVERY ROOM	0.059280	1,484,916	88,026	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.425667	22,157	9,432	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.232019	1,378,177	319,763	54.00
54.01	03630	ULTRA SOUND	0.086020	315,112	27,106	54.01
54.02	03440	MAMMOGRAPHY	0.186122	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.093759	152,683	14,315	55.00
56.00	05600	RADIOISOTOPE	0.062508	282,127	17,635	56.00
57.00	05700	CT SCAN	0.019224	6,940,973	133,433	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.048805	983,100	47,980	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040648	4,867,369	197,849	59.00
60.00	06000	LABORATORY	0.066920	11,786,741	788,769	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.134480	2,201,298	296,031	62.00
65.00	06500	RESPIRATORY THERAPY	0.108226	5,372,464	581,440	65.00
66.00	06600	PHYSICAL THERAPY	0.216605	2,069,552	448,275	66.00
69.00	06900	ELECTROCARDIOLOGY	0.053433	4,486,793	239,743	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.072040	185,254	13,346	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.074549	9,880,459	736,578	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.207274	4,003,339	829,788	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123981	26,587,778	3,296,379	73.00
74.00	07400	RENAL DIALYSIS	0.800874	416,543	333,598	74.00
76.00	03950	LITHOTRIPSY	0.069986	0	0	76.00
76.01	03330	ENDOSCOPY	0.070451	1,006,198	70,888	76.01
76.02	03040	PRISION CLINIC	0.927036	0	0	76.02
76.03	03050	WOUND CARE	0.220654	12,980	2,864	76.03
76.04	03060	OPIC	0.166595	8,586	1,430	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.098668	6,094,887	601,370	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.861701	112,468	96,914	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		107,592,775	11,166,202	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)		107,592,775		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D-3 | Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT				35.00
40.00	04000	SUBPROVIDER - IPF		1,905,231		40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.116479	0	0	50.00
51.00	05100	RECOVERY ROOM	0.059280	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.425667	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.232019	2,906	674	54.00
54.01	03630	ULTRA SOUND	0.086020	3,208	276	54.01
54.02	03440	MAMMOGRAPHY	0.186122	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.093759	0	0	55.00
56.00	05600	RADIOISOTOPE	0.062508	0	0	56.00
57.00	05700	CT SCAN	0.019224	33,063	636	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.048805	5,798	283	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040648	6,996	284	59.00
60.00	06000	LABORATORY	0.066920	174,892	11,704	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.134480	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.108226	15,808	1,711	65.00
66.00	06600	PHYSICAL THERAPY	0.216605	2,927	634	66.00
69.00	06900	ELECTROCARDIOLOGY	0.053433	18,830	1,006	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.072040	9,136	658	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.074549	2,312	172	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.207274	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123981	182,198	22,589	73.00
74.00	07400	RENAL DIALYSIS	0.800874	0	0	74.00
76.00	03950	LITHOTRIPSY	0.069986	0	0	76.00
76.01	03330	ENDOSCOPY	0.070451	0	0	76.01
76.02	03040	PRISION CLINIC	0.927036	0	0	76.02
76.03	03050	WOUND CARE	0.220654	0	0	76.03
76.04	03060	OPIC	0.166595	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.098668	138,172	13,633	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.861701	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		596,246	54,260	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)		596,246		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D-3 | Date/Time Prepared: 1/24/2023 4:19 pm

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
35.00	02060	NEONATAL INTENSIVE CARE UNIT				35.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF		1,945,621		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.116479	77,404	9,016	50.00
51.00	05100	RECOVERY ROOM	0.059280	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.425667	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.232019	273,645	63,491	54.00
54.01	03630	ULTRA SOUND	0.086020	88,129	7,581	54.01
54.02	03440	MAMMOGRAPHY	0.186122	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.093759	0	0	55.00
56.00	05600	RADIOISOTOPE	0.062508	4,713	295	56.00
57.00	05700	CT SCAN	0.019224	180,338	3,467	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.048805	39,977	1,951	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040648	40,068	1,629	59.00
60.00	06000	LABORATORY	0.066920	620,766	41,542	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.134480	44,479	5,982	62.00
65.00	06500	RESPIRATORY THERAPY	0.108226	59,996	6,493	65.00
66.00	06600	PHYSICAL THERAPY	0.216605	2,629,115	569,479	66.00
69.00	06900	ELECTROCARDIOLOGY	0.053433	13,160	703	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.072040	26,730	1,926	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.074549	243,830	18,177	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.207274	76,826	15,924	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123981	1,756,095	217,722	73.00
74.00	07400	RENAL DIALYSIS	0.800874	64,408	51,583	74.00
76.00	03950	LITHOTRIPSY	0.069986	0	0	76.00
76.01	03330	ENDOSCOPY	0.070451	0	0	76.01
76.02	03040	PRISION CLINIC	0.927036	0	0	76.02
76.03	03050	WOUND CARE	0.220654	0	0	76.03
76.04	03060	OPIC	0.166595	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.098668	5,197	513	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.861701	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,244,876	1,017,474	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)		6,244,876		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D-3 | Date/Time Prepared: 1/24/2023 4:19 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,321,280		30.00
31.00	03100	INTENSIVE CARE UNIT		3,125,541		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		892,556		35.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		1,057,323		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.116479	10,364,342	1,207,228	50.00
51.00	05100	RECOVERY ROOM	0.059280	828,757	49,129	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.425667	3,358,280	1,429,509	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.232019	736,268	170,828	54.00
54.01	03630	ULTRA SOUND	0.086020	231,975	19,954	54.01
54.02	03440	MAMMOGRAPHY	0.186122	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.093759	58,808	5,514	55.00
56.00	05600	RADIOISOTOPE	0.062508	160,612	10,040	56.00
57.00	05700	CT SCAN	0.019224	3,667,810	70,510	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.048805	506,931	24,741	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040648	2,884,106	117,233	59.00
60.00	06000	LABORATORY	0.066920	7,356,567	492,301	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.134480	1,273,763	171,296	62.00
65.00	06500	RESPIRATORY THERAPY	0.108226	4,563,741	493,915	65.00
66.00	06600	PHYSICAL THERAPY	0.213844	753,738	161,182	66.00
69.00	06900	ELECTROCARDIOLOGY	0.052918	1,988,062	105,204	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.072040	99,140	7,142	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.074549	4,545,193	338,840	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.207274	1,939,071	401,919	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123981	17,933,687	2,223,436	73.00
74.00	07400	RENAL DIALYSIS	0.800874	81,699	65,431	74.00
76.00	03950	LITHOTRIPSY	0.069986	0	0	76.00
76.01	03330	ENDOSCOPY	0.070451	366,457	25,817	76.01
76.02	03040	PRISION CLINIC	0.927036	0	0	76.02
76.03	03050	WOUND CARE	0.218198	13,470	2,939	76.03
76.04	03060	OPIC	0.165144	5,521	912	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.098182	4,131,348	405,624	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.861701	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		67,849,346	8,000,644	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)		67,849,346		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D-3 | Date/Time Prepared: 1/24/2023 4:19 pm

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
35.00	02060	NEONATAL INTENSIVE CARE UNIT				35.00
40.00	04000	SUBPROVIDER - IPF		15,319,428		40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.116479	707	82	50.00
51.00	05100	RECOVERY ROOM	0.059280	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.425667	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.232019	42,079	9,763	54.00
54.01	03630	ULTRA SOUND	0.086020	7,524	647	54.01
54.02	03440	MAMMOGRAPHY	0.186122	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.093759	0	0	55.00
56.00	05600	RADIOISOTOPE	0.062508	0	0	56.00
57.00	05700	CT SCAN	0.019224	184,970	3,556	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.048805	51,889	2,532	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040648	0	0	59.00
60.00	06000	LABORATORY	0.066920	1,310,816	87,720	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.134480	1,276	172	62.00
65.00	06500	RESPIRATORY THERAPY	0.108226	76,484	8,278	65.00
66.00	06600	PHYSICAL THERAPY	0.213844	4,710	1,007	66.00
69.00	06900	ELECTROCARDIOLOGY	0.052918	143,728	7,606	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.072040	26,730	1,926	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.074549	5,271	393	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.207274	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123981	1,365,425	169,287	73.00
74.00	07400	RENAL DIALYSIS	0.800874	3,274	2,622	74.00
76.00	03950	LITHOTRIPSY	0.069986	0	0	76.00
76.01	03330	ENDOSCOPY	0.070451	14,513	1,022	76.01
76.02	03040	PRISION CLINIC	0.927036	0	0	76.02
76.03	03050	WOUND CARE	0.218198	0	0	76.03
76.04	03060	OPIC	0.165144	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.098182	1,230,688	120,831	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.861701	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,470,084	417,444	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)		4,470,084		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet D-3 | Date/Time Prepared: 1/24/2023 4:19 pm

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
35.00	02060	NEONATAL INTENSIVE CARE UNIT				35.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF		589,904		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.116479	17,157	1,998	50.00
51.00	05100	RECOVERY ROOM	0.059280	3,371	200	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.425667	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.232019	23,998	5,568	54.00
54.01	03630	ULTRA SOUND	0.086020	1,923	165	54.01
54.02	03440	MAMMOGRAPHY	0.186122	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.093759	0	0	55.00
56.00	05600	RADIOISOTOPE	0.062508	14,124	883	56.00
57.00	05700	CT SCAN	0.019224	70,063	1,347	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.048805	5,798	283	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040648	16,763	681	59.00
60.00	06000	LABORATORY	0.066920	128,191	8,579	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.134480	23,373	3,143	62.00
65.00	06500	RESPIRATORY THERAPY	0.108226	179,774	19,456	65.00
66.00	06600	PHYSICAL THERAPY	0.213844	766,522	163,916	66.00
69.00	06900	ELECTROCARDIOLOGY	0.052918	30,869	1,634	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.072040	4,568	329	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.074549	21,600	1,610	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.207274	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123981	677,424	83,988	73.00
74.00	07400	RENAL DIALYSIS	0.800874	0	0	74.00
76.00	03950	LITHOTRIPSY	0.069986	0	0	76.00
76.01	03330	ENDOSCOPY	0.070451	0	0	76.01
76.02	03040	PRISION CLINIC	0.927036	0	0	76.02
76.03	03050	WOUND CARE	0.218198	0	0	76.03
76.04	03060	OPIC	0.165144	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.098182	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.861701	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,985,518	293,780	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)		1,985,518		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046	Period: From 09/01/2021 To 08/31/2022	Worksheet E Part A Date/Time Prepared: 1/24/2023 4:19 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,051,697	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	11,413,473	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)	17,403	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	548,801	2.04
3.00	Managed Care Simulated Payments	7,691,737	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	155.25	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5.73	30.00
31.00	Percentage of Medicaid patient days (see instructions)	24.76	31.00
32.00	Sum of lines 30 and 31	30.49	32.00
33.00	Allowable disproportionate share percentage (see instructions)	14.37	33.00
34.00	Disproportionate share adjustment (see instructions)	447,811	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet E Part A Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,386,287	1,297,826	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	113,942	1,191,155	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,305,097		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	14,784,282		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		14,784,282	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,075,671	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		204,442	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		16,064,395	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		16,064,395	61.00
62.00	Deductibles billed to program beneficiaries		1,391,181	62.00
63.00	Coinsurance billed to program beneficiaries		11,771	63.00
64.00	Allowable bad debts (see instructions)		134,685	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		87,545	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		41,737	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		14,748,988	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-5,680	70.93
70.94	HRR adjustment amount (see instructions)		-116,227	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet E Part A Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Hospital | PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		14,627,081	71.00
71.01	Sequestration adjustment (see instructions)		86,300	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		13,877,005	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		663,776	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		535,990	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046	Period: From 09/01/2021 To 08/31/2022	Worksheet E Part B Date/Time Prepared: 1/24/2023 4:19 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	18,005	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	10,361,736	2.00
3.00	OPPS payments	11,772,946	3.00
4.00	Outlier payment (see instructions)	23,554	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)	18,005	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	145,305	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)	145,305	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	145,305	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	127,300	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)	18,005	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)	11,796,500	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,004,486	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	9,810,019	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)	9,810,019	30.00
31.00	Primary payer payments	339	31.00
32.00	Subtotal (line 30 minus line 31)	9,809,680	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)	65,149	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	42,347	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	21,404	36.00
37.00	Subtotal (see instructions)	9,852,027	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
39.97	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)	9,852,027	40.00
40.01	Sequestration adjustment (see instructions)	58,127	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	9,860,271	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-66,371	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	132,511	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: 15-0046	Period: From 09/01/2021 To 08/31/2022	Worksheet E Part B Date/Time Prepared: 1/24/2023 4:19 pm
	Title XVIII	Hospital	PPS

		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	0	200.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2021 To 08/31/2022	Worksheet E Part B Date/Time Prepared: 1/24/2023 4:19 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	24	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	58	2.00
3.00	OPPS payments	75	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)	24	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	192	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)	192	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	192	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	168	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	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)	75	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)	99	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)	99	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	99	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)	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)	99	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
39.97	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)	99	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	113	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-14	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: 15-0046 Component CCN: 15-S046	Period: From 09/01/2021 To 08/31/2022	Worksheet E Part B Date/Time Prepared: 1/24/2023 4:19 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days		200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		13,877,005		9,860,271	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		13,877,005		9,860,271	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		663,776		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		66,371	6.02
7.00	Total Medicare program liability (see instructions)		14,540,781		9,793,900	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: 15-0046 Component CCN: 15-S046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet E-1 Part I Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Subprovider - IPF | 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		251,739		113	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		251,739		113	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		5,317		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		14	6.02
7.00	Total Medicare program liability (see instructions)		257,056		99	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: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 1/24/2023 4:19 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,209,900		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,209,900		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		24,871		0	6.02
7.00	Total Medicare program liability (see instructions)		2,185,029		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0046	Period: From 09/01/2021 To 08/31/2022	Worksheet E-1 Part II Date/Time Prepared: 1/24/2023 4:19 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2021 To 08/31/2022	Worksheet E-3 Part II Date/Time Prepared: 1/24/2023 4:19 pm
	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)	308,028	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	12.271233	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) 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)	308,028	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)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	308,028	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	308,028	18.00
19.00	Deductibles	55,008	19.00
20.00	Subtotal (line 18 minus line 19)	253,020	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	253,020	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	8,556	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	5,561	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,484	25.00
26.00	Subtotal (sum of lines 22 and 24)	258,581	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.98	Recovery of accelerated depreciation.	0	30.98
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	258,581	31.00
31.01	Sequestration adjustment (see instructions)	1,525	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	251,739	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)	5,317	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	0	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: 15-0046 Component CCN: 15-T046	Period: From 09/01/2021 To 08/31/2022	Worksheet E-3 Part III Date/Time Prepared: 1/24/2023 4:19 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	1,706,520	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0563	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	106,658	3.00
4.00	Outlier Payments	399,403	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)	5.493151	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)	2,212,581	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)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	2,212,581	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	2,212,581	19.00
20.00	Deductibles	4,668	20.00
21.00	Subtotal (line 19 minus line 20)	2,207,913	21.00
22.00	Coinsurance	9,916	22.00
23.00	Subtotal (line 21 minus line 22)	2,197,997	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	2,197,997	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)	0	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)	2,197,997	32.00
32.01	Sequestration adjustment (see instructions)	12,968	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	2,209,900	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)	-24,871	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	399,403	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: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet E-3 Part VII | Date/Time Prepared: 1/24/2023 4:19 pm

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	9,064,801		1.00
2.00	Medical and other services		9,129,879	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	9,064,801	9,129,879	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)	9,064,801	9,129,879	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	9,396,700		8.00
9.00	Ancillary service charges	67,849,346	99,023,304	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)	77,246,046	99,023,304	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)	77,246,046	99,023,304	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	68,181,245	89,893,425	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)	9,064,801	9,129,879	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	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	9,064,801	9,129,879	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)	9,064,801	9,129,879	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	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)	9,064,801	9,129,879	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	9,064,801	9,129,879	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)	9,064,801	9,129,879	40.00
41.00	Interim payments	12,905,296	8,294,980	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-3,840,495	834,899	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: 15-0046 Component CCN: 15-S046	Period: From 09/01/2021 To 08/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 1/24/2023 4:19 pm
	Title XIX	Subprovider - IPF	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	417,444		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	417,444	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)	417,444	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	15,319,428		8.00
9.00	Ancillary service charges	4,470,084	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)	19,789,512	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)	19,789,512	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	19,372,068	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)	417,444	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		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	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	417,444	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)	417,444	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	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)	417,444	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	417,444	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)	417,444	0	40.00
41.00	Interim payments	2,495,197	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-2,077,753	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: 15-0046 Component CCN: 15-T046	Period: From 09/01/2021 To 08/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 1/24/2023 4:19 pm
	Title XIX	Subprovider - IRF	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	384,975		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	384,975	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)	384,975	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	589,904		8.00
9.00	Ancillary service charges	1,985,518	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)	2,575,422	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)	2,575,422	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	2,190,447	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)	384,975	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		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	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	384,975	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)	384,975	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	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)	384,975	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	384,975	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)	384,975	0	40.00
41.00	Interim payments	487,005	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-102,030	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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet G | Date/Time Prepared: 1/24/2023 4:19 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	24,324	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	22,931,190	0	0	0	4.00
5.00	Other receivable	68,704	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,793,595	0	0	0	6.00
7.00	Inventory	7,110,309	0	0	0	7.00
8.00	Prepaid expenses	730,831	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	121,664	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	26,193,427	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,262,718	0	0	0	12.00
13.00	Land improvements	3,238,473	0	0	0	13.00
14.00	Accumulated depreciation	-3,130,797	0	0	0	14.00
15.00	Buildings	38,638,215	0	0	0	15.00
16.00	Accumulated depreciation	-30,046,179	0	0	0	16.00
17.00	Leasehold improvements	9,572,776	0	0	0	17.00
18.00	Accumulated depreciation	-8,072,765	0	0	0	18.00
19.00	Fixed equipment	31,608,284	0	0	0	19.00
20.00	Accumulated depreciation	-25,499,888	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	47,255,308	0	0	0	23.00
24.00	Accumulated depreciation	-39,203,881	0	0	0	24.00
25.00	Minor equipment depreciable	6,940,654	0	0	0	25.00
26.00	Accumulated depreciation	-5,549,173	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	2,011,451	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	29,025,196	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,063,197	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	2,654,822	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,718,019	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	60,936,642	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,652,015	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,501,681	0	0	0	38.00
39.00	Payroll taxes payable	7,534,642	0	0	0	39.00
40.00	Notes and loans payable (short term)	271,465	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	176,334	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,136,137	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	763,064	0	0	0	47.00
48.00	Unsecured loans	-310,150,122	0	0	0	48.00
49.00	Other long term liabilities	120,960	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-309,266,098	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-294,129,961	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	355,066,603				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	355,066,603	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	60,936,642	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet G-1 | Date/Time Prepared: 1/24/2023 4:19 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		342,269,117		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		18,547,665				2.00
3.00	Total (sum of line 1 and line 2)		360,816,782		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)		360,816,782		0		11.00
12.00	FEDERAL TAX LIABILITY ENTRY	5,750,177		0		0	12.00
13.00	ROUNDING	2		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)		5,750,179		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		355,066,603		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	FEDERAL TAX LIABILITY ENTRY		0		12.00
13.00	ROUNDING		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: 15-0046 | Period: From 09/01/2021 To 08/31/2022 | Worksheet G-2 Parts I & II Date/Time Prepared: 1/24/2023 4:19 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	22,173,085		22,173,085	1.00
2.00	SUBPROVIDER - IPF	23,856,800		23,856,800	2.00
3.00	SUBPROVIDER - IRF	3,650,040		3,650,040	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)	49,679,925		49,679,925	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	14,051,221		14,051,221	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	NEONATAL INTENSIVE CARE UNIT	110		110	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	14,051,331		14,051,331	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	63,731,256		63,731,256	17.00
18.00	Ancillary services	319,366,967	362,448,783	681,815,750	18.00
19.00	Outpatient services	19,647,543	53,607,656	73,255,199	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OCCUPATIONAL MEDICINE	0	293,081	293,081	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	402,745,766	416,349,520	819,095,286	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		110,444,962		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	MISCELLANEOUS INCOME	73,815			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)		73,815		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		110,371,147		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0046	Period: From 09/01/2021 To 08/31/2022	Worksheet G-3 Date/Time Prepared: 1/24/2023 4:19 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	819,095,286	1.00
2.00	Less contractual allowances and discounts on patients' accounts	690,474,313	2.00
3.00	Net patient revenues (line 1 minus line 2)	128,620,973	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	110,371,147	4.00
5.00	Net income from service to patients (line 3 minus line 4)	18,249,826	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	297,842	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	297,842	25.00
26.00	Total (line 5 plus line 25)	18,547,668	26.00
27.00	ROUNDING	3	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	3	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	18,547,665	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0046	Period: From 09/01/2021 To 08/31/2022	Worksheet L Parts I-III Date/Time Prepared: 1/24/2023 4:19 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	933,816	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	82,464	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)	46.20	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	5.73	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	24.76	8.00
9.00	Sum of lines 7 and 8	30.49	9.00
10.00	Allowable disproportionate share percentage (see instructions)	6.36	10.00
11.00	Disproportionate share adjustment (see instructions)	59,391	11.00
12.00	Total prospective capital payments (see instructions)	1,075,671	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