

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: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet S Parts I-III Date/Time Prepared: 11/29/2022 8:09 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 11/29/2022	Time: 8:09 am
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ASCENSION ST. VINCENT ANDERSON (15-0088) for the cost reporting period beginning 07/01/2021 and ending 06/30/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
1		2		
1	Becky Jacobson	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	Becky Jacobson		2
3	Signatory Title	VP OF FINANCE		3
4	Date	11/29/2022 08:09:35 AM		4

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	790,180	-151,497	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	14,013	0		0	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	804,193	-151,497	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDI CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part I Date/Time Prepared: 11/29/2022 8:09 am
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1.00	2.00	3.00	4.00	
Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2015 JACKSON STREET	PO Box:		
2.00	City: ANDERSON	State: IN	Zip Code: 46016	County:

	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	ASCENSION ST. VINCENT ANDERSON	150088	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	BENNETT REHAB CENTER	15T088	26900	5	06/01/1989	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)	07/01/2021	06/30/2022	20.00
21.00	Type of Control (see instructions)	1		21.00
		1.00	2.00	3.00

Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				Y	N				22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	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: 15-0088			Period: From 07/01/2021 To 06/30/2022		Worksheet S-2 Part I Date/Time Prepared: 11/29/2022 8:09 am		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,248	294	5	25	7,647	9	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.	67	0	0	0	464		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.								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.								58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00

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		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y			60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.01	1		60.01	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
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	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
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

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

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		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.	N				70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0		71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	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
					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.	N		Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y		98.06
Rural Providers						
105.00	Does this hospital qualify as a CAH?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0088		Period: From 07/01/2021 To 06/30/2022		Worksheet S-2 Part I Date/Time Prepared: 11/29/2022 8:09 am	
		V		XIX			
		1.00		2.00			
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	
				1.00		2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
				1.00		2.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
				1.00		2.00	
				3.00			
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				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:	0		0		1,141,974	
				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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0088		Period: From 07/01/2021 To 06/30/2022		Worksheet S-2 Part I Date/Time Prepared: 11/29/2022 8:09 am	
		1.00		2.00			
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		15H046		140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: ST VINCENT HEALTH	Contractor's Name: WPS		Contractor's Number: 08101		141.00	
142.00	Street: 250 WEST 96TH STREET , SUITE 2058	PO Box:				142.00	
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46260		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.					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	
		1.00		2.00		3.00	
						Title XIX	
						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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						3.00	
						4.00	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					9.99	
						169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part I Date/Time Prepared: 11/29/2022 8:09 am	
			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. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0088		Period: From 07/01/2021 To 06/30/2022		Worksheet S-2 Part II Date/Time Prepared: 11/29/2022 8:09 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			Y			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		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.			Y			7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			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)			Y	10/06/2022	Y	10/06/2022
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part II Date/Time Prepared: 11/29/2022 8:09 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		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.	KATHY	ZAMBOS		41.00
42.00	Enter the employer/company name of the cost report preparer.	ST VINCENT HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	NA	KATHY.ZAMBOS@ASCENSION.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet S-2
Part II
Date/Time Prepared:
11/29/2022 8:09 am

		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.	LEAD ANALYST	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: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2022 8:09 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	Title V
	Line Number				Visits / Trips	
	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	123	44,895	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)		123	44,895	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	21	7,665	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		144	52,560	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	13	4,745		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)		157				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: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2022 8:09 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents			
	Title XVII I	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)	3,638	985	22,776			1.00
2.00	HMO and other (see instructions)	7,028	7,483				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	613	464				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	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,638	985	22,776			7.00
8.00	INTENSIVE CARE UNIT	3,281	198	5,098			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		553	674			13.00
14.00	Total (see instructions)	6,919	1,736	28,548	0.00	510.42	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	835	67	2,221	0.00	12.86	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)			222			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	523.28	27.00
28.00	Observation Bed Days		0	1,570			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			124			30.00
31.00	Employee discount days - IRF			27			31.00
32.00	Labor & delivery days (see instructions)	0	9	119			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: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2022 8:09 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	1,214	212	5,258	1.00
2.00	HMO and other (see instructions)			1,046	1,703		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				36		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,214	212	5,258	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	74	4	178	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: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part II Date/Time Prepared: 11/29/2022 8:09 am
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	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	49,275,651	-104,750	49,170,901	1,162,572.62	42.29
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		78,887	0	78,887	443.81	177.75
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		16,540	0	16,540	1,002.68	16.50
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		5,204,349	129,531	5,333,880	116,427.79	45.81
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		9,340,240	0	9,340,240	202,429.84	46.14
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		1,428,729	0	1,428,729	18,131.58	78.80
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		10,222,774	0	10,222,774	202,821.99	50.40
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		14,577,619	0	14,577,619		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,574,456	0	1,574,456		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		9,171	0	9,171		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		3,918,003	0	3,918,003		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet S-3
Part II
Date/Time Prepared:
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	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	410,102	-391,041	19,061	439.33	43.39	26.00
27.00	Administrative & General	1,981,081	-347,974	1,633,107	48,877.59	33.41	27.00
28.00	Administrative & General under contract (see inst.)	2,625,359	0	2,625,359	40,483.17	64.85	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	241	2	243	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)	2,360,992	0	2,360,992	88,021.75	26.82	33.00
34.00	Dietary	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)	778,551	0	778,551	25,712.00	30.28	35.00
36.00	Cafeteria	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	1,730,159	55,836	1,785,995	40,591.24	44.00	38.00
39.00	Central Services and Supply	439,693	1,594	441,287	18,862.61	23.39	39.00
40.00	Pharmacy	3,005,189	28,159	3,033,348	61,898.09	49.01	40.00
41.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	41.00
42.00	Social Service	0	0	0	0.00	0.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet S-3
Part III
Date/Time Prepared:
11/29/2022 8:09 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	55,024,013	-104,750	54,919,263	1,315,786.86	41.74	1.00
2.00	Excluded area salaries (see instructions)	5,204,349	129,531	5,333,880	116,427.79	45.81	2.00
3.00	Subtotal salaries (line 1 minus line 2)	49,819,664	-234,281	49,585,383	1,199,359.07	41.34	3.00
4.00	Subtotal other wages & related costs (see inst.)	20,991,743	0	20,991,743	423,383.41	49.58	4.00
5.00	Subtotal wage-related costs (see inst.)	18,504,793	0	18,504,793	0.00	37.32	5.00
6.00	Total (sum of lines 3 thru 5)	89,316,200	-234,281	89,081,919	1,622,742.48	54.90	6.00
7.00	Total overhead cost (see instructions)	13,331,367	-653,424	12,677,943	324,885.78	39.02	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part IV Date/Time Prepared: 11/29/2022 8:09 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,735,823	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	243,456	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)	6,806,133	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,764,588	9.00
10.00	Dental, Hearing and Vision Plan	143,215	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	31,516	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	244,312	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	191,217	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	3,520,765	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	4,617	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	14,986	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	14,700,628	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: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part V Date/Time Prepared: 11/29/2022 8:09 am
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		9,340,240	14,700,628
2.00	Hospital		9,340,240	14,700,628
3.00	SUBPROVIDER - IPF			
4.00	SUBPROVIDER - IRF		0	0
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	SKILLED NURSING FACILITY			
9.00	NURSING FACILITY			
10.00	OTHER LONG TERM CARE I			
11.00	Hospital-Based HHA			
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			
13.00	Hospital-Based Hospice			
14.00	Hospital-Based Health Clinic RHC			
15.00	Hospital-Based Health Clinic FQHC			
16.00	Hospital-Based-CMHC			
17.00	RENAL DIALYSIS I			
18.00	Other		0	0

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet S-10 Date/Time Prepared: 11/29/2022 8:09 am
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			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)		0.239898	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		40,464,397	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			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		166,617,508	6.00	
7.00	Medicaid cost (line 1 times line 6)		39,971,207	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00	
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	16,197,456	1,087,069	17,284,525	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,885,737	1,087,069	4,972,806	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)	3,885,737	1,087,069	4,972,806	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)			7,863,494	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			312,315	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			480,484	27.01
28.00	Non-Medicare bad debt expense (see instructions)			7,383,010	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,939,338	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			6,912,144	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			6,912,144	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 15-0088		Period: From 07/01/2021 To 06/30/2022		Worksheet A	
Date/Time Prepared: 11/29/2022 8:09 am								
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,797,285	3,797,285	-1,982	3,795,303	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MAB		0	0	0	0	1.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	410,102	7,952,976	8,363,078	-446,914	7,916,164	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,981,081	52,736,264	54,717,345	-378,115	54,339,230	5.00
7.00	00700	OPERATION OF PLANT	0	5,466,190	5,466,190	0	5,466,190	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	861,958	861,958	0	861,958	8.00
9.00	00900	HOUSEKEEPING	241	2,892,187	2,892,428	2	2,892,430	9.00
10.00	01000	DIETARY	0	2,903,443	2,903,443	-1,828,117	1,075,326	10.00
11.00	01100	CAFETERIA	0	0	0	1,828,117	1,828,117	11.00
13.00	01300	NURSING ADMINISTRATION	1,730,159	753,565	2,483,724	74,899	2,558,623	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	439,693	144,059	583,752	5,348	589,100	14.00
15.00	01500	PHARMACY	3,005,189	699,862	3,705,051	28,159	3,733,210	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6	6	0	6	16.00
23.00	02300	ALLIED HEALTH-EMS	0	0	0	0	0	23.00
23.01	02301	ALLIED HEALTH-RAD TECH	75,970	33,642	109,612	26,576	136,188	23.01
23.02	02303	ALLIED HEALTH-PHARM RESIDENTS	0	0	0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,842,521	3,385,597	16,228,118	553,090	16,781,208	30.00
31.00	03100	INTENSIVE CARE UNIT	5,034,603	2,489,413	7,524,016	53,353	7,577,369	31.00
41.00	04100	SUBPROVIDER - IIRF	1,333,167	277,845	1,611,012	90,792	1,701,804	41.00
43.00	04300	NURSERY	0	0	0	269,936	269,936	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	699,187	13,586,604	14,285,791	6,552	14,292,343	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,412,307	299,470	1,711,777	-551,521	1,160,256	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,925,371	1,005,205	2,930,576	-5,049	2,925,527	54.00
54.01	03440	MAMMOGRAPHY	269,885	263,336	533,221	-402	532,819	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	284,371	636,570	920,941	2,665	923,606	54.02
54.03	03630	ULTRA SOUND	333,305	88,720	422,025	3,123	425,148	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	905,529	911,842	1,817,371	9,149	1,826,520	55.00
57.00	05700	CT SCAN	652,204	210,646	862,850	6,111	868,961	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	292,494	248,361	540,855	2,741	543,596	58.00
59.00	05900	CARDIAC CATHETERIZATION	802,110	289,646	1,091,756	7,516	1,099,272	59.00
60.00	06000	LABORATORY	0	6,324,768	6,324,768	0	6,324,768	60.00
65.00	06500	RESPIRATORY THERAPY	1,344,893	195,599	1,540,492	50,724	1,591,216	65.00
66.00	06600	PHYSICAL THERAPY	2,634,180	571,466	3,205,646	-1,186,577	2,019,069	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	897,848	897,848	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	314,027	314,027	68.00
69.00	06900	ELECTROCARDIOLOGY	121,641	70,048	191,689	1,140	192,829	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	230,582	327,889	558,471	2,161	560,632	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,685,468	4,685,468	0	4,685,468	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,897,421	4,897,421	0	4,897,421	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,644,532	19,644,532	0	19,644,532	73.00
76.00	03190	CHEMOTHERAPY	715,675	213,262	928,937	52,538	981,475	76.00
76.01	03020	WOUND CARE	435,834	549,283	985,117	4,084	989,201	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	1,029,678	92,482	1,122,160	9,648	1,131,808	90.01
90.02	04950	DIABETIC EDUCATION	0	0	0	0	0	90.02
90.03	09002	MS CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	4,538,467	2,994,649	7,533,116	60,175	7,593,291	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	17,232	10,485	27,717	0	27,717	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,497,671	142,512,044	188,009,715	-38,203	187,971,512	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	80,744	21,522	102,266	757	103,023	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,612,935	433,499	3,046,434	15,017	3,061,451	192.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	CHILDRENS CLINIC	0	214	214	0	214	194.01
194.02	07952	PSS ADMINISTRATION	15,837	5,498	21,335	148	21,483	194.02
194.03	07953	SEXUAL ASSAULT PROGRAM	1,957	147	2,104	18	2,122	194.03
194.04	07954	ASPR BIOTERRORISM GRANT	0	440	440	0	440	194.04
194.05	07955	HEALTHY FAMILIES	254,813	86,975	341,788	2,388	344,176	194.05
194.06	07956	DME-HOME CARE	0	-15,954	-15,954	0	-15,954	194.06
194.07	07957	MARKETING	0	0	0	0	0	194.07
194.08	07958	CORPORATE COMMUNICATIONS	0	0	0	0	0	194.08
194.09	07959	MOB	0	360	360	0	360	194.09

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0088		Period: From 07/01/2021 To 06/30/2022	Worksheet A Date/Time Prepared: 11/29/2022 8:09 am		
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
194.10	07960 ASC	0	0	0	0	0	194.10
194.11	07961 MAB	0	0	0	0	0	194.11
194.12	07963 ADOLESCENT RESIDENTIAL SERVICES	811,694	79,462	891,156	19,875	911,031	194.12
194.13	07962 IDLE SPACE	0	0	0	0	0	194.13
200.00	TOTAL (SUM OF LINES 118 through 199)	49,275,651	143,124,207	192,399,858	0	192,399,858	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet A
Date/Time Prepared:
11/29/2022 8:09 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-520,087	3,275,216	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MAB	0	0	1.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	413,642	8,329,806	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-9,265,889	45,073,341	5.00
7.00	00700	OPERATION OF PLANT	-490,161	4,976,029	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	861,958	8.00
9.00	00900	HOUSEKEEPING	0	2,892,430	9.00
10.00	01000	DIETARY	-333,616	741,710	10.00
11.00	01100	CAFETERIA	0	1,828,117	11.00
13.00	01300	NURSING ADMINISTRATION	-143,547	2,415,076	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-659,592	-70,492	14.00
15.00	01500	PHARMACY	-58,940	3,674,270	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6	16.00
23.00	02300	ALLIED HEALTH-EMS	0	0	23.00
23.01	02301	ALLIED HEALTH-RAD TECH	0	136,188	23.01
23.02	02303	ALLIED HEALTH-PHARM RESIDENTS	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-389	16,780,819	30.00
31.00	03100	INTENSIVE CARE UNIT	-379,264	7,198,105	31.00
41.00	04100	SUBPROVIDER - IRF	0	1,701,804	41.00
43.00	04300	NURSERY	0	269,936	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-793,521	13,498,822	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-24,285	1,135,971	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,748	2,923,779	54.00
54.01	03440	MAMMOGRAPHY	0	532,819	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	923,606	54.02
54.03	03630	ULTRA SOUND	0	425,148	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	-281	1,826,239	55.00
57.00	05700	CT SCAN	0	868,961	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-5,112	538,484	58.00
59.00	05900	CARDIAC CATHETERIZATION	-425	1,098,847	59.00
60.00	06000	LABORATORY	-213	6,324,555	60.00
65.00	06500	RESPIRATORY THERAPY	-1,639	1,589,577	65.00
66.00	06600	PHYSICAL THERAPY	-6,808	2,012,261	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	897,848	67.00
68.00	06800	SPEECH PATHOLOGY	0	314,027	68.00
69.00	06900	ELECTROCARDIOLOGY	-424	192,405	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-267,718	292,914	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,685,468	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,897,421	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,644,532	73.00
76.00	03190	CHEMOTHERAPY	-893	980,582	76.00
76.01	03020	WOUND CARE	-30,000	959,201	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	-40,945	1,090,863	90.01
90.02	04950	DIABETIC EDUCATION	0	0	90.02
90.03	09002	MS CLINIC	0	0	90.03
91.00	09100	EMERGENCY	-1,212,989	6,380,302	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-27,717	0	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,852,561	174,118,951	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	103,023	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,061,451	192.00
194.00	07950	FOUNDATION	0	0	194.00
194.01	07951	CHILDRENS CLINIC	0	214	194.01
194.02	07952	PSS ADMINISTRATION	0	21,483	194.02
194.03	07953	SEXUAL ASSAULT PROGRAM	0	2,122	194.03
194.04	07954	ASPR BIOTERRORISM GRANT	0	440	194.04
194.05	07955	HEALTHY FAMILIES	0	344,176	194.05
194.06	07956	DME-HOME CARE	0	-15,954	194.06
194.07	07957	MARKETING	0	0	194.07
194.08	07958	CORPORATE COMMUNICATIONS	0	0	194.08
194.09	07959	MOB	0	360	194.09
194.10	07960	ASC	0	0	194.10
194.11	07961	MAB	0	0	194.11

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet A Date/Time Prepared: 11/29/2022 8:09 am
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Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
194.12	07963 ADOLESCENT RESIDENTIAL SERVICES	0	911,031	194.12
194.13	07962 IDLE SPACE	0	0	194.13
200.00	TOTAL (SUM OF LINES 118 through 199)	-13,852,561	178,547,297	200.00

RECLASSIFICATIONS

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet A-6
Date/Time Prepared:
11/29/2022 8:09 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
B - INSURANCE EXPENSE RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	574	1.00	
	TOTALS		0	574		
C - INTEREST EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,556	1.00	
	TOTALS		0	2,556		
D - CAFETERIA/DIETARY RECLASS						
1.00	CAFETERIA	11.00	0	1,828,117	1.00	
	TOTALS		0	1,828,117		
E - LABOR DELIVERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	243,241	51,578	1.00	
2.00	NURSERY	43.00	222,712	47,224	2.00	
	TOTALS		465,953	98,802		
H - PT_OT_ST RECLASS						
1.00	OCCUPATIONAL THERAPY	67.00	737,790	160,058	1.00	
2.00	SPEECH PATHOLOGY	68.00	258,046	55,981	2.00	
	TOTALS		995,836	216,039		
J - ADOLESCENT RESIDENTIAL SERVICES						
1.00	ADOLESCENT RESIDENTIAL SERVICES	194.12	0	12,269	1.00	
	TOTALS		0	12,269		
M - RAD TECH RECLASS						
1.00	ALLIED HEALTH-RAD TECH	23.01	25,866	0	1.00	
	TOTALS		25,866	0		
O - SYSTEM PROJECTS						
1.00	NURSING ADMINISTRATION	13.00	56,007	0	1.00	
2.00	CENTRAL SERVICES & SUPPLY	14.00	1,228	0	2.00	
3.00	ADULTS & PEDIATRICS	30.00	144,492	0	3.00	
4.00	INTENSIVE CARE UNIT	31.00	6,424	0	4.00	
5.00	SUBPROVIDER - IRF	41.00	78,707	0	5.00	
6.00	RADIOLOGY-THERAPEUTIC	55.00	528	0	6.00	
7.00	RESPIRATORY THERAPY	65.00	1,372	0	7.00	
8.00	CHEMOTHERAPY	76.00	45,832	0	8.00	
9.00	EMERGENCY	91.00	17,487	0	9.00	
	TOTALS		352,077	0		
Q - PHYSICIAN RECLASS						
1.00	RESPIRATORY THERAPY	65.00	0	36,750	1.00	
	TOTALS		0	36,750		
T - VACCINE						
1.00	NURSING ADMINISTRATION	13.00	2,903	2,903	1.00	
2.00	ADULTS & PEDIATRICS	30.00	5,710	5,710	2.00	
3.00	RADIOLOGY-THERAPEUTIC	55.00	136	136	3.00	
4.00	PHYSICAL THERAPY	66.00	615	615	4.00	
5.00		0.00	0	0	5.00	
	TOTALS		9,364	9,364		
U - FURLOUGH						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,627	1.00	
2.00	NURSING ADMINISTRATION	13.00	0	16,160	2.00	
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,754	3.00	
4.00	ADULTS & PEDIATRICS	30.00	0	22,594	4.00	
5.00	INTENSIVE CARE UNIT	31.00	0	4,984	5.00	
6.00	SUBPROVIDER - IRF	41.00	0	3,026	6.00	
7.00	OPERATING ROOM	50.00	0	5,198	7.00	
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	11,761	8.00	
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	15,936	9.00	
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,931	10.00	
11.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.02	0	1,771	11.00	
12.00	ULTRA SOUND	54.03	0	1,766	12.00	
13.00	RADIOLOGY-THERAPEUTIC	55.00	0	7,046	13.00	
14.00	CT SCAN	57.00	0	805	14.00	
15.00	CARDIAC CATHETERIZATION	59.00	0	5,038	15.00	
16.00	RESPIRATORY THERAPY	65.00	0	2,729	16.00	
17.00	PHYSICAL THERAPY	66.00	0	13,351	17.00	
18.00	ELECTROCARDIOLOGY	69.00	0	1,718	18.00	
19.00	CHEMOTHERAPY	76.00	0	5,069	19.00	
20.00	WOUND CARE	76.01	0	2,023	20.00	
21.00	ANDERSON OUTPATIENT CENTER	90.01	0	4,170	21.00	
22.00	EMERGENCY	91.00	0	4,057	22.00	
23.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	950	23.00	
24.00	ADOLESCENT RESIDENTIAL SERVICES	194.12	0	9,795	24.00	
	TOTALS		0	151,259		

RECLASSIFICATIONS

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet A-6

Date/Time Prepared:
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		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
W - ACCRUED PTO						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	55,873	0	1.00	
	TOTALS		55,873	0		
X - STARP						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	176	0	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	18,094	0	2.00	
3.00	HOUSEKEEPING	9.00	2	0	3.00	
4.00	NURSING ADMINISTRATION	13.00	15,989	0	4.00	
5.00	CENTRAL SERVICES & SUPPLY	14.00	4,120	0	5.00	
6.00	PHARMACY	15.00	28,159	0	6.00	
7.00	ALLIED HEALTH-RAD TECH	23.01	710	0	7.00	
8.00	ADULTS & PEDIATRICS	30.00	120,338	0	8.00	
9.00	INTENSIVE CARE UNIT	31.00	46,929	0	9.00	
10.00	SUBPROVIDER - IRF	41.00	12,085	0	10.00	
11.00	OPERATING ROOM	50.00	6,552	0	11.00	
12.00	DELIVERY ROOM & LABOR ROOM	52.00	13,234	0	12.00	
13.00	RADIOLOGY-DIAGNOSTIC	54.00	17,886	0	13.00	
14.00	MAMMOGRAPHY	54.01	2,529	0	14.00	
15.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.02	2,665	0	15.00	
16.00	ULTRA SOUND	54.03	3,123	0	16.00	
17.00	RADIOLOGY-THERAPEUTIC	55.00	8,485	0	17.00	
18.00	CT SCAN	57.00	6,111	0	18.00	
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	2,741	0	19.00	
20.00	CARDIAC CATHETERIZATION	59.00	7,516	0	20.00	
21.00	RESPIRATORY THERAPY	65.00	12,602	0	21.00	
22.00	PHYSICAL THERAPY	66.00	24,683	0	22.00	
23.00	ELECTROCARDIOLOGY	69.00	1,140	0	23.00	
24.00	ELECTROENCEPHALOGRAPHY	70.00	2,161	0	24.00	
25.00	CHEMOTHERAPY	76.00	6,706	0	25.00	
26.00	WOUND CARE	76.01	4,084	0	26.00	
27.00	ANDERSON OUTPATIENT CENTER	90.01	9,648	0	27.00	
28.00	EMERGENCY	91.00	42,688	0	28.00	
29.00	RESEARCH	191.00	757	0	29.00	
30.00	PHYSICIANS' PRIVATE OFFICES	192.00	15,017	0	30.00	
31.00	PSS ADMINISTRATION	194.02	148	0	31.00	
32.00	SEXUAL ASSAULT PROGRAM	194.03	18	0	32.00	
33.00	HEALTHY FAMILIES	194.05	2,388	0	33.00	
34.00	ADOLESCENT RESIDENTIAL SERVICES	194.12	7,606	0	34.00	
	TOTALS		447,090	0		
500.00	Grand Total: Increases		2,352,059	2,355,730	500.00	

RECLASSIFICATIONS

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet A-6
Date/Time Prepared:
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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
B - INSURANCE EXPENSE RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	574	12		1.00
	TOTALS		0	574			
C - INTEREST EXPENSE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,556	11		1.00
	TOTALS		0	2,556			
D - CAFETERIA/DIETARY RECLASS							
1.00	DIETARY	10.00	0	1,828,117	0		1.00
	TOTALS		0	1,828,117			
E - LABOR DELIVERY RECLASS							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	465,953	98,802	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		465,953	98,802			
H - PT_OT_ST RECLASS							
1.00	PHYSICAL THERAPY	66.00	995,836	216,039	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		995,836	216,039			
J - ADOLESCENT RESIDENTIAL SERVICES							
1.00	ADULTS & PEDIATRICS	30.00	0	12,269	0		1.00
	TOTALS		0	12,269			
M - RAD TECH RECLASS							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	25,866	0	0		1.00
	TOTALS		25,866	0			
O - SYSTEM PROJECTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	352,077	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	TOTALS		352,077	0			
Q - PHYSICIAN RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	36,750	0		1.00
	TOTALS		0	36,750			
T - VACCINE							
1.00	ADMINISTRATIVE & GENERAL	5.00	9,364	0	0		1.00
2.00	NURSING ADMINISTRATION	13.00	2,903	0	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	5,710	0	0		3.00
4.00	RADIOLOGY-THERAPEUTIC	55.00	136	0	0		4.00
5.00	PHYSICAL THERAPY	66.00	615	0	0		5.00
	TOTALS		18,728	0			
U - FURLOUGH							
1.00	ADMINISTRATIVE & GENERAL	5.00	4,627	0	0		1.00
2.00	NURSING ADMINISTRATION	13.00	16,160	0	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	3,754	0	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	22,594	0	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	4,984	0	0		5.00
6.00	SUBPROVIDER - IRF	41.00	3,026	0	0		6.00
7.00	OPERATING ROOM	50.00	5,198	0	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	11,761	0	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	15,936	0	0		9.00
10.00	MAMMOGRAPHY	54.01	2,931	0	0		10.00
11.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.02	1,771	0	0		11.00
12.00	ULTRA SOUND	54.03	1,766	0	0		12.00
13.00	RADIOLOGY-THERAPEUTIC	55.00	7,046	0	0		13.00
14.00	CT SCAN	57.00	805	0	0		14.00
15.00	CARDIAC CATHETERIZATION	59.00	5,038	0	0		15.00
16.00	RESPIRATORY THERAPY	65.00	2,729	0	0		16.00
17.00	PHYSICAL THERAPY	66.00	13,351	0	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	1,718	0	0		18.00
19.00	CHEMOTHERAPY	76.00	5,069	0	0		19.00
20.00	WOUND CARE	76.01	2,023	0	0		20.00
21.00	ANDERSON OUTPATIENT CENTER	90.01	4,170	0	0		21.00
22.00	EMERGENCY	91.00	4,057	0	0		22.00
23.00	PHYSICIANS' PRIVATE OFFICES	192.00	950	0	0		23.00
24.00	ADOLESCENT RESIDENTIAL SERVICES	194.12	9,795	0	0		24.00
	TOTALS		151,259	0			

RECLASSIFICATIONS

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet A-6

Date/Time Prepared:
11/29/2022 8:09 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	W - ACCRUED PTO						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	55,873	0		1.00
	TOTALS		0	55,873			
	X - STARP						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	447,090	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0	0		31.00
32.00		0.00	0	0	0		32.00
33.00		0.00	0	0	0		33.00
34.00		0.00	0	0	0		34.00
	TOTALS		447,090	0	0		
500.00	Grand Total: Decreases		2,456,809	2,250,980			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet A-7
Part I
Date/Time Prepared:
11/29/2022 8:09 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	5,292,602	0	0	0	1.00
2.00	Land Improvements	1,754,357	1,171,786	0	1,171,786	2.00
3.00	Buildings and Fixtures	69,496,615	428,735	0	428,735	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	40,712,995	922,917	0	922,917	5.00
6.00	Movable Equipment	61,619,356	4,643,317	0	4,643,317	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	178,875,925	7,166,755	0	7,166,755	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	178,875,925	7,166,755	0	7,166,755	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	5,292,602	0			1.00
2.00	Land Improvements	2,926,143	0			2.00
3.00	Buildings and Fixtures	69,925,350	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	41,558,039	0			5.00
6.00	Movable Equipment	62,371,330	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	182,073,464	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	182,073,464	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet A-7
Part II
Date/Time Prepared:
11/29/2022 8:09 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	3,232,774	0	564,511	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MAB	0	0	0	0	0	1.01
3.00	Total (sum of lines 1-2)	3,232,774	0	564,511	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	3,797,285				1.00
1.01	CAP REL COSTS-BLDG & FIXT-MAB	0	0				1.01
3.00	Total (sum of lines 1-2)	0	3,797,285				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet A-7
Part III
Date/Time Prepared:
11/29/2022 8:09 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	182,073,464	0	182,073,464	1.000000	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MAB	0	0	0	0.000000	0	1.01
3.00	Total (sum of lines 1-2)	182,073,464	0	182,073,464	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	3,229,057	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MAB	0	0	0	0	0	1.01
3.00	Total (sum of lines 1-2)	0	0	0	3,229,057	0	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	45,585	574	0	0	3,275,216	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MAB	0	0	0	0	0	1.01
3.00	Total (sum of lines 1-2)	45,585	574	0	0	3,275,216	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet A-8

Date/Time Prepared:
11/29/2022 8:09 am

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				1.00	2.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-494,348	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT-MAB (chapter 2)		0	CAP REL COSTS-BLDG & FIXT-MAB	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-70,163	ADMINISTRATIVE & GENERAL	5.00	11	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-15,335	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-6,952	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,671,238			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	9,147,675			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-333,616	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-1,702	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-55,281	ADMINISTRATIVE & GENERAL	5.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	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
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT-MAB		0	CAP REL COSTS-BLDG & FIXT-MAB	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	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	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet A-8

Date/Time Prepared:
11/29/2022 8:09 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
			Cost Center		Line #		
			1.00	2.00	3.00		4.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00		0 32.00
33.00 LEASE INCOME	B	-483,209		OPERATION OF PLANT	7.00		0 33.00
33.01 AMBULANCE COST	B	-27,717		AMBULANCE SERVICES	95.00		0 33.01
33.02 DUES REVENUE	B	-800		ADMINISTRATIVE & GENERAL	5.00		0 33.02
33.03 PHYSICIAN FUND EXPENSE	A	-7,349,561		ADMINISTRATIVE & GENERAL	5.00		0 33.03
33.04 OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00		0 33.04
33.05 OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00		0 33.05
33.06 OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00		0 33.06
33.07 OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00		0 33.07
33.08 OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00		0 33.08
33.09 OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00		0 33.09
33.10 OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00		0 33.10
33.11 OTHER MISCELLANEOUS REVENUE	B	-248,972		ADMINISTRATIVE & GENERAL	5.00		0 33.11
33.12 OTHER MISCELLANEOUS REVENUE	B	-24		INTENSIVE CARE UNIT	31.00		0 33.12
33.13 OTHER MISCELLANEOUS REVENUE	B	-1,663		RADIOLOGY-DIAGNOSTIC	54.00		0 33.13
33.14 OTHER MISCELLANEOUS REVENUE	B	-5,112		MAGNETIC RESONANCE IMAGING (MRI)	58.00		9 33.14
33.15 OTHER MISCELLANEOUS REVENUE	B	-1,170		RESPIRATORY THERAPY	65.00		0 33.15
33.16 OTHER MISCELLANEOUS REVENUE	B	-6,808		PHYSICAL THERAPY	66.00		0 33.16
33.17 OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00		0 33.17
33.18 ENTERTAINMENT	A	-23,102		ADMINISTRATIVE & GENERAL	5.00		0 33.18
33.19 ENTERTAINMENT	A	-710		DELIVERY ROOM & LABOR ROOM	52.00		0 33.19
33.20 ENTERTAINMENT	A	-632		NURSING ADMINISTRATION	13.00		0 33.20
36.00 ENTERTAINMENT	A	-206		ANDERSON OUTPATIENT CENTER	90.01		0 36.00
36.01 ENTERTAINMENT	A	-389		ADULTS & PEDIATRICS	30.00		0 36.01
36.02 ENTERTAINMENT	A	-70		RESPIRATORY THERAPY	65.00		0 36.02
36.03 ENTERTAINMENT	A	-56		PHARMACY	15.00		0 36.03
36.04 ENTERTAINMENT	A	-242		EMERGENCY	91.00		0 36.04
36.05 GAIN/LOSS ON DISPOSAL PPE	B	-16,349		CAP REL COSTS-BLDG & FIXT	1.00		11 36.05
36.06 GAIN/LOSS ON DISPOSAL PPE	B	-4,948		OPERATING ROOM	50.00		0 36.06
36.07 GAIN/LOSS ON DISPOSAL PPE	B	-106		DELIVERY ROOM & LABOR ROOM	52.00		0 36.07
36.08 GAIN/LOSS ON DISPOSAL PPE	B	-85		RADIOLOGY-DIAGNOSTIC	54.00		0 36.08
36.09 GAIN/LOSS ON DISPOSAL PPE	B	-106		RADIOLOGY-THERAPEUTIC	55.00		0 36.09
36.10 GAIN/LOSS ON DISPOSAL PPE	B	-425		CARDIAC CATHETERIZATION	59.00		0 36.10
36.11 GAIN/LOSS ON DISPOSAL PPE	B	-213		LABORATORY	60.00		0 36.11
36.12 GAIN/LOSS ON DISPOSAL PPE	B	-893		CHEMOTHERAPY	76.00		0 36.12
36.13 FED SPON PRJC REV	B	-1,200		PHARMACY	15.00		0 36.13
36.14 EQUIPMENT RENTAL	B	-6,440		OPERATING ROOM	50.00		0 36.14
36.15 CONTRACT SERVICE REVENUE	B	-22,739		ANDERSON OUTPATIENT CENTER	90.01		0 36.15
36.16 CHAIRTABLE CONTRIBUTIONS	A	-53,720		NURSING ADMINISTRATION	13.00		0 36.16
36.17 CHAIRTABLE CONTRIBUTION	A	-20,893		ADMINISTRATIVE & GENERAL	5.00		0 36.17
36.18 CORPORATE SPONSORSHIPS	A	-3,433		ADMINISTRATIVE & GENERAL	5.00		0 36.18
36.19 COMMUNITY BENEFITS	A	-2,800		ADMINISTRATIVE & GENERAL	5.00		0 36.19
36.20 SHARED SAVINGS PAYMENT	B	-505		ADMINISTRATIVE & GENERAL	5.00		0 36.20
36.21 STATE PROGRAM REVENUE	B	-8,500		ADMINISTRATIVE & GENERAL	5.00		0 36.21
36.22 NONFED STATE SPONSOR	B	-175		RADIOLOGY-THERAPEUTIC	55.00		0 36.22
36.23 OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00		0 36.23
36.24 LOBBYING EXPENSE	A	-2,537		ADMINISTRATIVE & GENERAL	5.00		0 36.24
36.25 DEPRECIATION AHA LIFE ADJUSTMENT	A	-3,717		CAP REL COSTS-BLDG & FIXT	1.00		9 36.25
36.26 PROMOTIONAL ITEMS	A	-26,244		ADMINISTRATIVE & GENERAL	5.00		0 36.26
36.27 PROMOTIONAL ITEMS	A	-3,252		DELIVERY ROOM & LABOR ROOM	52.00		0 36.27
36.28 CHAIRTABLE CONTRIBUTIONS	A	-20,217		DELIVERY ROOM & LABOR ROOM	52.00		0 36.28
36.29 PROMOTIONAL ITEMS	A	-399		RESPIRATORY THERAPY	65.00		0 36.29
36.30 PROMOTIONAL ITEMS	A	-424		ELECTROCARDIOLOGY	69.00		0 36.30
36.31 PROVIDER TAX	A	-10,904,629		ADMINISTRATIVE & GENERAL	5.00		0 36.31
36.32 MARKETING EXPENSE	A	-5,195		ADMINISTRATIVE & GENERAL	5.00		0 36.32

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet A-8

Date/Time Prepared:
11/29/2022 8:09 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
36.33 BILLING ARRANGEMENTS	B	-16,432	ADMINISTRATIVE & GENERAL	5.00	0	36.33
36.34 BILLING ARRANGEMENTS	B	-55,982	PHARMACY	15.00	0	36.34
36.35 BILLING ARRANGEMENTS	B	-600	OPERATING ROOM	50.00	0	36.35
36.36 BILLING ARRANGEMENTS	B	-18,000	ANDERSON OUTPATIENT CENTER	90.01	0	36.36
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,852,561				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 15-0088

Period: From 07/01/2021 To 06/30/2022

Worksheet A-8-1

Date/Time Prepared: 11/29/2022 8:09 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - CAPITAL	2,566,347	0
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - INTEREST - CA	67,203	0
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - A&G	404	0
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - OTHER	40,863,910	33,835,971
4.01	8.00	LAUNDRY & LINEN SERVICE	SVH CHARGEBACK	-16,348	-16,348
4.02	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACK	-33,504	-33,504
4.03	15.00	PHARMACY	SVH CHARGEBACK	-8,000	-8,000
4.04	23.01	ALLIED HEALTH-RAD TECH	SVH CHARGEBACK	28,370	28,370
4.05	31.00	INTENSIVE CARE UNIT	SVH CHARGEBACK	25,000	25,000
4.06	50.00	OPERATING ROOM	SVH CHARGEBACK	525,000	525,000
4.07	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACK	20,675	20,675
4.08	55.00	RADIOLOGY-THERAPEUTIC	SVH CHARGEBACK	8,970	8,970
4.09	59.00	CARDIAC CATHETERIZATION	SVH CHARGEBACK	90,000	90,000
4.10	91.00	EMERGENCY	SVH CHARGEBACK	59,600	59,600
4.11	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	494,348	500,021
4.12	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	2,556	0
4.13	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	7,326,204	6,912,562
4.14	14.00	CENTRAL SERVICES & SUPPLY	TRG ADMIN FEES - SUPPLIES	-659,592	0
4.15	13.00	NURSING ADMINISTRATION	TRG ADMIN FEES -CONTRACTED L	-89,195	0
4.16	5.00	ADMINISTRATIVE & GENERAL	TRG ADMIN FEES - OTHER	-175,956	0
4.17	0.00			0	0
4.18	0.00			0	0
4.19	0.00			0	0
4.20	0.00			0	0
4.21	0.00			0	0
4.22	0.00			0	0
4.23	0.00			0	0
4.24	0.00			0	0
4.25	0.00			0	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			51,095,992	41,948,317

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

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

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

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

6.00	G	ST VINCENT HEAL	100.00	ST VINCENT HEAL	100.00	6.00
7.00	G	ASCENSION HEALT	100.00	ASCENSION HEALT	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	FINANCIAL				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: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet A-8-1

Date/Time Prepared:
11/29/2022 8:09 am

	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	2,566,347	0	1.00
2.00	67,203	0	2.00
3.00	404	0	3.00
4.00	7,027,939	0	4.00
4.01	0	0	4.01
4.02	0	0	4.02
4.03	0	0	4.03
4.04	0	0	4.04
4.05	0	0	4.05
4.06	0	0	4.06
4.07	0	0	4.07
4.08	0	0	4.08
4.09	0	0	4.09
4.10	0	0	4.10
4.11	-5,673	11	4.11
4.12	2,556	0	4.12
4.13	413,642	0	4.13
4.14	-659,592	0	4.14
4.15	-89,195	0	4.15
4.16	-175,956	0	4.16
4.17	0	0	4.17
4.18	0	0	4.18
4.19	0	0	4.19
4.20	0	0	4.20
4.21	0	0	4.21
4.22	0	0	4.22
4.23	0	0	4.23
4.24	0	0	4.24
4.25	0	0	4.25
5.00	9,147,675		5.00

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

Related Organization(s) and/or Home Office	Type of Business
	6.00

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet A-8-2

Date/Time Prepared:
11/29/2022 8:09 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	31.00	INTENSIVE CARE UNIT	379,240	379,240	0	197,500	0	1.00
2.00	50.00	OPERATING ROOM	1,678,884	781,533	897,351	246,400	8,040	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	228,499	0	228,499	271,900	8,760	3.00
4.00	70.00	ELECTROENCEPHALOGRAPHY	267,718	267,718	0	179,000	0	4.00
5.00	76.01	WOUND CARE	30,000	30,000	0	179,000	0	5.00
6.00	91.00	EMERGENCY	1,212,747	1,212,747	0	179,000	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,797,088	2,671,238	1,125,850		16,800	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	952,431	47,622	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	1,145,117	57,256	0	0	0	3.00
4.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	4.00
5.00	76.01	WOUND CARE	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,097,548	104,878	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	31.00	INTENSIVE CARE UNIT	0	0	0	379,240	1.00
2.00	50.00	OPERATING ROOM	0	952,431	0	781,533	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	1,145,117	0	0	3.00
4.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	267,718	4.00
5.00	76.01	WOUND CARE	0	0	0	30,000	5.00
6.00	91.00	EMERGENCY	0	0	0	1,212,747	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	2,097,548	0	2,671,238	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet B
Part I
Date/Time Prepared:
11/29/2022 8:09 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	BLDG & FIXT-MAB			
	0	1.00	1.01	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	3,275,216	3,275,216			1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT-MAB	0	0	0		1.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	8,329,806	43,012	0	8,372,818	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	45,073,341	360,286	0	278,193	45,711,820
7.00 00700	OPERATION OF PLANT	4,976,029	387,178	0	0	5,363,207
8.00 00800	LAUNDRY & LINEN SERVICE	861,958	4,660	0	0	866,618
9.00 00900	HOUSEKEEPING	2,892,430	69,293	0	41	2,961,764
10.00 01000	DIETARY	741,710	71,599	0	0	813,309
11.00 01100	CAFETERIA	1,828,117	121,723	0	0	1,949,840
13.00 01300	NURSING ADMINISTRATION	2,415,076	33,921	0	304,237	2,753,234
14.00 01400	CENTRAL SERVICES & SUPPLY	-70,492	110,152	0	75,171	114,831
15.00 01500	PHARMACY	3,674,270	33,469	0	516,719	4,224,458
16.00 01600	MEDICAL RECORDS & LIBRARY	6	36,213	0	0	36,219
23.00 02300	ALLIED HEALTH-EMS	0	0	0	0	0
23.01 02301	ALLIED HEALTH-RAD TECH	136,188	764	0	17,468	154,420
23.02 02303	ALLIED HEALTH-PHARM RESIDENTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	16,780,819	454,742	0	2,270,372	19,505,933
31.00 03100	INTENSIVE CARE UNIT	7,198,105	101,818	0	865,864	8,165,787
41.00 04100	SUBPROVIDER - IRF	1,701,804	69,453	0	242,050	2,013,307
43.00 04300	NURSERY	269,936	43,297	0	37,938	351,171
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	13,498,822	333,352	0	119,334	13,951,508
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,135,971	154,706	0	161,459	1,452,136
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,923,779	99,165	0	323,905	3,346,849
54.01 03440	MAMMOGRAPHY	532,819	0	0	45,905	578,724
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	923,606	7,827	0	48,594	980,027
54.03 03630	ULTRA SOUND	425,148	0	0	57,008	482,156
55.00 05500	RADIOLOGY-THERAPEUTIC	1,826,239	0	0	154,588	1,980,827
57.00 05700	CT SCAN	868,961	3,827	0	112,004	984,792
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	538,484	6,966	0	50,292	595,742
59.00 05900	CARDIAC CATHETERIZATION	1,098,847	59,465	0	137,058	1,295,370
60.00 06000	LABORATORY	6,324,555	87,121	0	0	6,411,676
65.00 06500	RESPIRATORY THERAPY	1,589,577	49,575	0	231,013	1,870,165
66.00 06600	PHYSICAL THERAPY	2,012,261	68,501	0	281,016	2,361,778
67.00 06700	OCCUPATIONAL THERAPY	897,848	30,844	0	125,680	1,054,372
68.00 06800	SPEECH PATHOLOGY	314,027	10,786	0	43,957	368,770
69.00 06900	ELECTROCARDIOLOGY	192,405	0	0	20,623	213,028
70.00 07000	ELECTROENCEPHALOGRAPHY	292,914	80,871	0	39,647	413,432
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,685,468	0	0	0	4,685,468
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	4,897,421	0	0	0	4,897,421
73.00 07300	DRUGS CHARGED TO PATIENTS	19,644,532	0	0	0	19,644,532
76.00 03190	CHEMOTHERAPY	980,582	0	0	129,999	1,110,581
76.01 03020	WOUND CARE	959,201	21,530	0	74,594	1,055,325
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0
90.01 09001	ANDERSON OUTPATIENT CENTER	1,090,863	24,308	0	176,335	1,291,506
90.02 04950	DIABETIC EDUCATION	0	0	0	0	0
90.03 09002	MS CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	6,380,302	157,206	0	782,669	7,320,177
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	2,935	2,935
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	174,118,951	3,137,630	0	7,726,668	173,335,215
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	13,071	0	0	13,071
191.00 19100	RESEARCH	103,023	0	0	13,883	116,906
192.00 19200	PHYSICIANS' PRIVATE OFFICES	3,061,451	12,703	0	447,499	3,521,653
194.00 07950	FOUNDATION	0	4,417	0	0	4,417
194.01 07951	CHILDRENS CLINIC	214	0	0	0	214
194.02 07952	PSS ADMINISTRATION	21,483	0	0	2,723	24,206
194.03 07953	SEXUAL ASSAULT PROGRAM	2,122	0	0	336	2,458
194.04 07954	ASPR BIOTERRORISM GRANT	440	0	0	0	440
194.05 07955	HEALTHY FAMILIES	344,176	70,085	0	43,813	458,074
194.06 07956	DME-HOME CARE	-15,954	0	0	0	-15,954

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet B
Part I
Date/Time Prepared:
11/29/2022 8:09 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	BLDG & FIXT-MAB			
	0	1.00	1.01	4.00	4A	
194.07 07957 MARKETING	0	0	0	0	0	194.07
194.08 07958 CORPORATE COMMUNICATIONS	0	17,551	0	0	17,551	194.08
194.09 07959 MOB	360	0	0	0	360	194.09
194.10 07960 ASC	0	0	0	0	0	194.10
194.11 07961 MAB	0	0	0	0	0	194.11
194.12 07963 ADOLESCENT RESIDENTIAL SERVICES	911,031	19,759	0	137,896	1,068,686	194.12
194.13 07962 IDLE SPACE	0	0	0	0	0	194.13
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	178,547,297	3,275,216	0	8,372,818	178,547,297	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0088		Period: From 07/01/2021 To 06/30/2022		Worksheet B Part I Date/Time Prepared: 11/29/2022 8:09 am	
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
1.01	00101	CAP REL COSTS-BLDG & FIXT-MAB						1.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	45,711,820					5.00
7.00	00700	OPERATION OF PLANT	1,845,383	7,208,590				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	298,188	13,520	1,178,326			8.00
9.00	00900	HOUSEKEEPING	1,019,090	201,029	0	4,181,883		9.00
10.00	01000	DIETARY	279,845	207,718	0	37,707	1,338,579	10.00
11.00	01100	CAFETERIA	670,905	353,135	0	22,145	0	11.00
13.00	01300	NURSING ADMINISTRATION	947,338	98,409	0	14,963	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	39,511	319,567	20,633	49,677	0	14.00
15.00	01500	PHARMACY	1,453,560	97,099	0	11,970	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,462	105,058	0	2,993	0	16.00
23.00	02300	ALLIED HEALTH-EMS	0	0	0	0	0	23.00
23.01	02301	ALLIED HEALTH-RAD TECH	53,133	2,216	0	0	0	23.01
23.02	02303	ALLIED HEALTH-PHARM RESIDENTS	0	0	0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,711,640	1,319,271	434,978	1,850,693	1,068,869	30.00
31.00	03100	INTENSIVE CARE UNIT	2,809,700	295,388	128,544	329,188	91,116	31.00
41.00	04100	SUBPROVIDER - IRF	692,743	201,492	45,097	149,631	101,572	41.00
43.00	04300	NURSERY	120,832	125,610	8,886	23,582	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,800,463	967,103	187,226	550,642	383	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	499,654	448,824	30,120	100,253	23,950	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,151,590	287,691	3,095	104,742	0	54.00
54.01	03440	MAMMOGRAPHY	199,129	0	6,903	8,978	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	337,210	22,708	592	8,978	0	54.02
54.03	03630	ULTRA SOUND	165,901	0	668	0	0	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	681,567	0	15,929	8,978	0	55.00
57.00	05700	CT SCAN	338,849	11,102	57,654	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	204,984	20,210	10,131	8,978	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	445,714	172,518	0	17,956	1,175	59.00
60.00	06000	LABORATORY	2,206,142	252,752	0	74,815	0	60.00
65.00	06500	RESPIRATORY THERAPY	643,490	143,825	0	5,985	0	65.00
66.00	06600	PHYSICAL THERAPY	812,645	198,732	12,143	78,167	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	362,790	89,483	5,260	35,193	0	67.00
68.00	06800	SPEECH PATHOLOGY	126,887	31,292	1,019	12,330	0	68.00
69.00	06900	ELECTROCARDIOLOGY	73,299	0	142	89,779	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	142,255	234,618	0	41,897	102	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,612,185	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,685,114	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,759,365	0	0	0	0	73.00
76.00	03190	CHEMOTHERAPY	382,131	0	21,075	0	16,252	76.00
76.01	03020	WOUND CARE	363,118	62,463	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	444,384	70,522	0	35,911	0	90.01
90.02	04950	DIABETIC EDUCATION	0	0	0	0	0	90.02
90.03	09002	MS CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	2,518,741	456,078	171,193	421,959	35,160	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,010	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,912,947	6,809,433	1,161,288	4,098,090	1,338,579	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	4,497	37,921	0	0	0	190.00
191.00	19100	RESEARCH	40,225	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,211,737	36,853	0	0	0	192.00
194.00	07950	FOUNDATION	1,520	12,815	0	1,496	0	194.00
194.01	07951	CHILDRENS CLINIC	74	0	232	53,867	0	194.01
194.02	07952	PSS ADMINISTRATION	8,329	0	0	0	0	194.02
194.03	07953	SEXUAL ASSAULT PROGRAM	846	0	0	0	0	194.03
194.04	07954	ASPR BIOTERRORISM GRANT	151	0	0	0	0	194.04
194.05	07955	HEALTHY FAMILIES	157,615	203,326	0	0	0	194.05
194.06	07956	DME-HOME CARE	0	0	0	0	0	194.06
194.07	07957	MARKETING	0	0	0	0	0	194.07
194.08	07958	CORPORATE COMMUNICATIONS	6,039	50,917	0	2,993	0	194.08
194.09	07959	MOB	124	0	16,806	19,452	0	194.09
194.10	07960	ASC	0	0	0	5,985	0	194.10
194.11	07961	MAB	0	0	0	0	0	194.11

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet B
Part I
Date/Time Prepared:
11/29/2022 8:09 am

Cost Center Description		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
194.12	07963 ADOLESCENT RESIDENTIAL SERVICES	367,716	57,325	0	0	0	194.12
194.13	07962 IDLE SPACE	0	0	0	0	0	194.13
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)	45,711,820	7,208,590	1,178,326	4,181,883	1,338,579	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0088		Period: From 07/01/2021 To 06/30/2022		Worksheet B Part I Date/Time Prepared: 11/29/2022 8:09 am	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MAB						1.01
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	2,996,025					11.00
13.00	01300	NURSING ADMINISTRATION	132,573	3,946,517				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	61,608	0	605,827			14.00
15.00	01500	PHARMACY	202,164	0	8,245	5,997,496		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	156,732	16.00
23.00	02300	ALLIED HEALTH-EMS	0	0	0	0	0	23.00
23.01	02301	ALLIED HEALTH-RAD TECH	8,858	0	0	0	0	23.01
23.02	02303	ALLIED HEALTH-PHARM RESIDENTS	0	0	0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	909,713	1,950,333	29,901	0	11,936	30.00
31.00	03100	INTENSIVE CARE UNIT	252,046	747,975	16,817	0	5,411	31.00
41.00	04100	SUBPROVIDER - I RF	87,377	204,097	1,062	0	892	41.00
43.00	04300	NURSERY	14,485	39,642	610	0	351	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	634	159,802	443,850	0	29,184	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	65,671	202,489	3,870	0	985	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	186,078	0	20,947	0	3,850	54.00
54.01	03440	MAMMOGRAPHY	20,318	0	3,161	0	871	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	18,852	0	10,003	0	3,673	54.02
54.03	03630	ULTRA SOUND	23,010	0	201	0	2,069	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	81,146	0	867	0	6,784	55.00
57.00	05700	CT SCAN	49,654	0	23	0	3,820	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	20,126	0	95	0	655	58.00
59.00	05900	CARDIAC CATHETERIZATION	64,547	109,300	8,770	0	5,435	59.00
60.00	06000	LABORATORY	0	0	147	0	19,408	60.00
65.00	06500	RESPIRATORY THERAPY	92,668	0	11,315	0	4,475	65.00
66.00	06600	PHYSICAL THERAPY	98,283	0	2,626	0	1,973	66.00
67.00	06700	OCCUPATIONAL THERAPY	67,977	0	1,183	0	816	67.00
68.00	06800	SPEECH PATHOLOGY	23,774	0	414	0	286	68.00
69.00	06900	ELECTROCARDIOLOGY	12,581	0	67	0	273	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,963	0	79	0	878	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,658	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,731	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,997,496	23,578	73.00
76.00	03190	CHEMOTHERAPY	78,621	0	5,586	0	1,948	76.00
76.01	03020	WOUND CARE	39,043	0	14,001	0	1,094	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	40,519	0	29	0	846	90.01
90.02	04950	DIABETIC EDUCATION	0	0	0	0	0	90.02
90.03	09002	MS CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	272,789	532,879	21,940	0	15,852	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,932,078	3,946,517	605,809	5,997,496	156,732	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	6,813	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,548	0	4	0	0	192.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	CHILDRENS CLINIC	0	0	0	0	0	194.01
194.02	07952	PSS ADMINISTRATION	2,352	0	0	0	0	194.02
194.03	07953	SEXUAL ASSAULT PROGRAM	88	0	0	0	0	194.03
194.04	07954	ASPR BIOTERRORISM GRANT	0	0	0	0	0	194.04
194.05	07955	HEALTHY FAMILIES	41,146	0	14	0	0	194.05
194.06	07956	DME-HOME CARE	0	0	0	0	0	194.06
194.07	07957	MARKETING	0	0	0	0	0	194.07
194.08	07958	CORPORATE COMMUNICATIONS	0	0	0	0	0	194.08
194.09	07959	MOB	0	0	0	0	0	194.09
194.10	07960	ASC	0	0	0	0	0	194.10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		11.00	13.00	14.00	15.00	16.00		
194.11	07961	MAB	0	0	0	0	0	194.11
194.12	07963	ADOLESCENT RESIDENTIAL SERVICES	0	0	0	0	0	194.12
194.13	07962	IDLE SPACE	0	0	0	0	0	194.13
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)	2,996,025	3,946,517	605,827	5,997,496	156,732	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0088		Period: From 07/01/2021 To 06/30/2022		Worksheet B Part I Date/Time Prepared: 11/29/2022 8:09 am	
Cost Center Description			ALLIED HEALTH-EMS	ALLIED HEALTH-RAD TECH	ALLIED HEALTH-PHARM RESIDENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			23.00	23.01	23.02	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MAB						1.01
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
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
23.00	02300	ALLIED HEALTH-EMS	0					23.00
23.01	02301	ALLIED HEALTH-RAD TECH		218,627				23.01
23.02	02303	ALLIED HEALTH-PHARM RESIDENTS			0			23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	33,793,267		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	12,841,972		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	3,497,270		41.00
43.00	04300	NURSERY	0	0	0	685,169		43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	21,090,795		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,827,952		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	38,742	0	5,143,584		54.00
54.01	03440	MAMMOGRAPHY	0	8,767	0	826,851		54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	36,966	0	1,419,009		54.02
54.03	03630	ULTRA SOUND	0	20,822	0	694,827		54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	68,297	0	2,844,395		55.00
57.00	05700	CT SCAN	0	38,441	0	1,484,335		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	6,592	0	867,513		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	2,120,785		59.00
60.00	06000	LABORATORY	0	0	0	8,964,940		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,771,923		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,566,347		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,617,074		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	564,772		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	389,169		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	840,224		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,302,311		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,587,266		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	32,424,971		73.00
76.00	03190	CHEMOTHERAPY	0	0	0	1,616,194		76.00
76.01	03020	WOUND CARE	0	0	0	1,535,044		76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	0	0	0	1,883,717		90.01
90.02	04950	DIABETIC EDUCATION	0	0	0	0		90.02
90.03	09002	MS CLINIC	0	0	0	0		90.03
91.00	09100	EMERGENCY	0	0	0	11,766,768		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	3,945		95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	218,627	0	170,972,389		118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	55,489		190.00
191.00	19100	RESEARCH	0	0	0	163,944		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	4,783,795		192.00
194.00	07950	FOUNDATION	0	0	0	20,248		194.00
194.01	07951	CHILDRENS CLINIC	0	0	0	54,387		194.01
194.02	07952	PSS ADMINISTRATION	0	0	0	34,887		194.02
194.03	07953	SEXUAL ASSAULT PROGRAM	0	0	0	3,392		194.03
194.04	07954	ASPR BIOTERRORISM GRANT	0	0	0	591		194.04
194.05	07955	HEALTHY FAMILIES	0	0	0	860,175		194.05
194.06	07956	DME-HOME CARE	0	0	0	-15,954		194.06
194.07	07957	MARKETING	0	0	0	0		194.07
194.08	07958	CORPORATE COMMUNICATIONS	0	0	0	77,500		194.08

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0088

Period:
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Cost Center Description			ALLIED HEALTH-EMS	ALLIED HEALTH-RAD TECH	ALLIED HEALTH-PHARM RESIDENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			23.00	23.01	23.02	24.00	25.00	
194.09	07959	MOB	0	0	0	36,742	0	194.09
194.10	07960	ASC	0	0	0	5,985	0	194.10
194.11	07961	MAB	0	0	0	0	0	194.11
194.12	07963	ADOLESCENT RESIDENTIAL SERVICES	0	0	0	1,493,727	0	194.12
194.13	07962	IDLE SPACE	0	0	0	0	0	194.13
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	218,627	0	178,547,297	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet B Part I Date/Time Prepared: 11/29/2022 8:09 am
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MAB	1.01
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
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
23.00	02300	ALLIED HEALTH-EMS	23.00
23.01	02301	ALLIED HEALTH-RAD TECH	23.01
23.02	02303	ALLIED HEALTH-PHARM RESIDENTS	23.02
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03440	MAMMOGRAPHY	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	54.02
54.03	03630	ULTRA SOUND	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03190	CHEMOTHERAPY	76.00
76.01	03020	WOUND CARE	76.01
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	90.01
90.02	04950	DIABETIC EDUCATION	90.02
90.03	09002	MS CLINIC	90.03
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	FOUNDATION	194.00
194.01	07951	CHILDRENS CLINIC	194.01
194.02	07952	PSS ADMINISTRATION	194.02
194.03	07953	SEXUAL ASSAULT PROGRAM	194.03
194.04	07954	ASPR BIOTERRORISM GRANT	194.04
194.05	07955	HEALTHY FAMILIES	194.05
194.06	07956	DME-HOME CARE	194.06
194.07	07957	MARKETING	194.07
194.08	07958	CORPORATE COMMUNICATIONS	194.08
194.09	07959	MOB	194.09
194.10	07960	ASC	194.10
194.11	07961	MAB	194.11
194.12	07963	ADOLESCENT RESIDENTIAL SERVICES	194.12

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Total	
		26.00	
194.13	07962 IDLE SPACE	0	194.13
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	178,547,297	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet B Part II Date/Time Prepared: 11/29/2022 8:09 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	BLDG & FIXT-MAB			
		0	1.00 1.01			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT-MAB					1.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	43,012	0	43,012	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,556,347	360,286	0	2,916,633	5.00
7.00 00700	OPERATION OF PLANT	0	387,178	0	387,178	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	4,660	0	4,660	8.00
9.00 00900	HOUSEKEEPING	0	69,293	0	69,293	9.00
10.00 01000	DIETARY	0	71,599	0	71,599	10.00
11.00 01100	CAFETERIA	0	121,723	0	121,723	11.00
13.00 01300	NURSING ADMINISTRATION	0	33,921	0	33,921	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	110,152	0	110,152	14.00
15.00 01500	PHARMACY	0	33,469	0	33,469	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	36,213	0	36,213	16.00
23.00 02300	ALLIED HEALTH-EMS	0	0	0	0	23.00
23.01 02301	ALLIED HEALTH-RAD TECH	0	764	0	764	23.01
23.02 02303	ALLIED HEALTH-PHARM RESIDENTS	0	0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	454,742	0	454,742	30.00
31.00 03100	INTENSIVE CARE UNIT	0	101,818	0	101,818	31.00
41.00 04100	SUBPROVIDER - IRF	0	69,453	0	69,453	41.00
43.00 04300	NURSERY	0	43,297	0	43,297	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	333,352	0	333,352	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	154,706	0	154,706	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	99,165	0	99,165	54.00
54.01 03440	MAMMOGRAPHY	0	0	0	0	54.01
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	7,827	0	7,827	54.02
54.03 03630	ULTRA SOUND	0	0	0	0	54.03
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00 05700	CT SCAN	0	3,827	0	3,827	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	6,966	0	6,966	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	59,465	0	59,465	59.00
60.00 06000	LABORATORY	0	87,121	0	87,121	60.00
65.00 06500	RESPIRATORY THERAPY	0	49,575	0	49,575	65.00
66.00 06600	PHYSICAL THERAPY	0	68,501	0	68,501	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	30,844	0	30,844	67.00
68.00 06800	SPEECH PATHOLOGY	0	10,786	0	10,786	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	80,871	0	80,871	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03190	CHEMOTHERAPY	0	0	0	0	76.00
76.01 03020	WOUND CARE	0	21,530	0	21,530	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	ANDERSON OUTPATIENT CENTER	0	24,308	0	24,308	90.01
90.02 04950	DIABETIC EDUCATION	0	0	0	0	90.02
90.03 09002	MS CLINIC	0	0	0	0	90.03
91.00 09100	EMERGENCY	0	157,206	0	157,206	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	2,556,347	3,137,630	0	5,693,977	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	13,071	0	13,071	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	12,703	0	12,703	192.00
194.00 07950	FOUNDATION	0	4,417	0	4,417	194.00
194.01 07951	CHILDRENS CLINIC	0	0	0	0	194.01
194.02 07952	PSS ADMINISTRATION	0	0	0	0	194.02
194.03 07953	SEXUAL ASSAULT PROGRAM	0	0	0	0	194.03
194.04 07954	ASPR BIOTERRORISM GRANT	0	0	0	0	194.04
194.05 07955	HEALTHY FAMILIES	0	70,085	0	70,085	194.05
194.06 07956	DME-HOME CARE	0	0	0	0	194.06
194.07 07957	MARKETING	0	0	0	0	194.07

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet B
Part II
Date/Time Prepared:
11/29/2022 8:09 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	BLDG & FIXT-MAB			
		1.00	1.01			
	0			2A	4.00	
194.08 07958 CORPORATE COMMUNICATIONS	0	17,551	0	17,551	0	194.08
194.09 07959 MOB	0	0	0	0	0	194.09
194.10 07960 ASC	0	0	0	0	0	194.10
194.11 07961 MAB	0	0	0	0	0	194.11
194.12 07963 ADOLESCENT RESIDENTIAL SERVICES	0	19,759	0	19,759	708	194.12
194.13 07962 IDLE SPACE	0	0	0	0	0	194.13
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)	2,556,347	3,275,216	0	5,831,563	43,012	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0088		Period: From 07/01/2021 To 06/30/2022		Worksheet B Part II Date/Time Prepared: 11/29/2022 8:09 am	
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
1.01	00101	CAP REL COSTS-BLDG & FIXT-MAB						1.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,918,062					5.00
7.00	00700	OPERATION OF PLANT	117,803	504,981				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	19,035	947	24,642			8.00
9.00	00900	HOUSEKEEPING	65,055	14,083	0	148,431		9.00
10.00	01000	DIETARY	17,864	14,551	0	1,338	105,352	10.00
11.00	01100	CAFETERIA	42,828	24,738	0	786	0	11.00
13.00	01300	NURSING ADMINISTRATION	60,475	6,894	0	531	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,522	22,387	432	1,763	0	14.00
15.00	01500	PHARMACY	92,790	6,802	0	425	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	796	7,360	0	106	0	16.00
23.00	02300	ALLIED HEALTH-EMS	0	0	0	0	0	23.00
23.01	02301	ALLIED HEALTH-RAD TECH	3,392	155	0	0	0	23.01
23.02	02303	ALLIED HEALTH-PHARM RESIDENTS	0	0	0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	428,448	92,416	9,097	65,690	84,126	30.00
31.00	03100	INTENSIVE CARE UNIT	179,362	20,693	2,688	11,684	7,171	31.00
41.00	04100	SUBPROVIDER - IRF	44,222	14,115	943	5,311	7,994	41.00
43.00	04300	NURSERY	7,713	8,799	186	837	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	306,445	67,748	3,915	19,544	30	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,896	31,441	630	3,558	1,885	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	73,514	20,154	65	3,718	0	54.00
54.01	03440	MAMMOGRAPHY	12,712	0	144	319	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	21,526	1,591	12	319	0	54.02
54.03	03630	ULTRA SOUND	10,591	0	14	0	0	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	43,509	0	333	319	0	55.00
57.00	05700	CT SCAN	21,631	778	1,206	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,085	1,416	212	319	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	28,453	12,085	0	637	92	59.00
60.00	06000	LABORATORY	140,832	17,706	0	2,655	0	60.00
65.00	06500	RESPIRATORY THERAPY	41,078	10,075	0	212	0	65.00
66.00	06600	PHYSICAL THERAPY	51,876	13,922	254	2,774	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,159	6,269	110	1,249	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,100	2,192	21	438	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,679	0	3	3,187	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,081	16,436	0	1,487	8	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	102,916	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	107,572	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	431,472	0	0	0	0	73.00
76.00	03190	CHEMOTHERAPY	24,394	0	441	0	1,279	76.00
76.01	03020	WOUND CARE	23,180	4,376	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	28,368	4,940	0	1,275	0	90.01
90.02	04950	DIABETIC EDUCATION	0	0	0	0	0	90.02
90.03	09002	MS CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	160,788	31,949	3,580	14,977	2,767	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	64	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,803,226	477,018	24,286	145,458	105,352	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	287	2,656	0	0	0	190.00
191.00	19100	RESEARCH	2,568	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	77,353	2,582	0	0	0	192.00
194.00	07950	FOUNDATION	97	898	0	53	0	194.00
194.01	07951	CHILDRENS CLINIC	5	0	5	1,912	0	194.01
194.02	07952	PSS ADMINISTRATION	532	0	0	0	0	194.02
194.03	07953	SEXUAL ASSAULT PROGRAM	54	0	0	0	0	194.03
194.04	07954	ASPR BIOTERRORISM GRANT	10	0	0	0	0	194.04
194.05	07955	HEALTHY FAMILIES	10,062	14,244	0	0	0	194.05
194.06	07956	DME-HOME CARE	0	0	0	0	0	194.06
194.07	07957	MARKETING	0	0	0	0	0	194.07
194.08	07958	CORPORATE COMMUNICATIONS	386	3,567	0	106	0	194.08
194.09	07959	MOB	8	0	351	690	0	194.09
194.10	07960	ASC	0	0	0	212	0	194.10
194.11	07961	MAB	0	0	0	0	0	194.11

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0088			Period: From 07/01/2021 To 06/30/2022		Worksheet B Part II Date/Time Prepared: 11/29/2022 8:09 am	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
194.12	07963 ADOLESCENT RESIDENTIAL SERVICES	23,474	4,016	0	0	0	0	194.12
194.13	07962 IDLE SPACE	0	0	0	0	0	0	194.13
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2,918,062	504,981	24,642	148,431	105,352		202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0088		Period: From 07/01/2021 To 06/30/2022		Worksheet B Part II Date/Time Prepared: 11/29/2022 8:09 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	190,075					11.00
13.00	01300	8,411	111,795				13.00
14.00	01400	3,909	0	126,797			14.00
15.00	01500	12,826	0	1,726	150,692		15.00
16.00	01600	0	0	0	0	44,475	16.00
23.00	02300	0	0	0	0	0	23.00
23.01	02301	562	0	0	0	0	23.01
23.02	02303	0	0	0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	57,716	55,248	6,258	0	3,364	30.00
31.00	03100	15,990	21,188	3,520	0	1,525	31.00
41.00	04100	5,543	5,782	222	0	251	41.00
43.00	04300	919	1,123	128	0	99	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	40	4,527	92,892	0	8,529	50.00
52.00	05200	4,166	5,736	810	0	278	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	11,805	0	4,384	0	1,085	54.00
54.01	03440	1,289	0	662	0	246	54.01
54.02	03450	1,196	0	2,094	0	1,035	54.02
54.03	03630	1,460	0	42	0	583	54.03
55.00	05500	5,148	0	181	0	1,912	55.00
57.00	05700	3,150	0	5	0	1,076	57.00
58.00	05800	1,277	0	20	0	185	58.00
59.00	05900	4,095	3,096	1,836	0	1,532	59.00
60.00	06000	0	0	31	0	5,470	60.00
65.00	06500	5,879	0	2,368	0	1,261	65.00
66.00	06600	6,235	0	550	0	556	66.00
67.00	06700	4,313	0	248	0	230	67.00
68.00	06800	1,508	0	87	0	80	68.00
69.00	06900	798	0	14	0	77	69.00
70.00	07000	442	0	17	0	248	70.00
71.00	07100	0	0	0	0	1,313	71.00
72.00	07200	0	0	0	0	1,333	72.00
73.00	07300	0	0	0	150,692	6,645	73.00
76.00	03190	4,988	0	1,169	0	549	76.00
76.01	03020	2,477	0	2,931	0	308	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	2,571	0	6	0	238	90.01
90.02	04950	0	0	0	0	0	90.02
90.03	09002	0	0	0	0	0	90.03
91.00	09100	17,306	15,095	4,592	0	4,467	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00							118.00
SUBTOTALS (SUM OF LINES 1 through 117)		186,019	111,795	126,793	150,692	44,475	
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	432	0	0	0	0	191.00
192.00	19200	859	0	1	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	149	0	0	0	0	194.02
194.03	07953	6	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	2,610	0	3	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	0	0	0	194.09
194.10	07960	0	0	0	0	0	194.10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0088

Period:
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
194.11	07961	MAB	0	0	0	0	194.11
194.12	07963	ADOLESCENT RESIDENTIAL SERVICES	0	0	0	0	194.12
194.13	07962	IDLE SPACE	0	0	0	0	194.13
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	14,754	0	201.00
202.00		TOTAL (sum lines 118 through 201)	190,075	111,795	141,551	150,692	44,475 202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0088		Period: From 07/01/2021 To 06/30/2022		Worksheet B Part II Date/Time Prepared: 11/29/2022 8:09 am	
Cost Center Description			ALLIED HEALTH-EMS	ALLIED HEALTH-RAD TECH	ALLIED HEALTH-PHARM RESIDENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			23.00	23.01	23.02	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MAB						1.01
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
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
23.00	02300	ALLIED HEALTH-EMS	0					23.00
23.01	02301	ALLIED HEALTH-RAD TECH		4,963				23.01
23.02	02303	ALLIED HEALTH-PHARM RESIDENTS			0			23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				1,268,770		30.00
31.00	03100	INTENSIVE CARE UNIT				370,087		31.00
41.00	04100	SUBPROVIDER - IRF				155,079		41.00
43.00	04300	NURSERY				63,296		43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				837,635		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				235,935		52.00
53.00	05300	ANESTHESIOLOGY				0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				215,554		54.00
54.01	03440	MAMMOGRAPHY				15,608		54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC				35,850		54.02
54.03	03630	ULTRA SOUND				12,983		54.03
55.00	05500	RADIOLOGY-THERAPEUTIC				52,196		55.00
57.00	05700	CT SCAN				32,248		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)				23,738		58.00
59.00	05900	CARDIAC CATHETERIZATION				111,995		59.00
60.00	06000	LABORATORY				253,815		60.00
65.00	06500	RESPIRATORY THERAPY				111,635		65.00
66.00	06600	PHYSICAL THERAPY				146,111		66.00
67.00	06700	OCCUPATIONAL THERAPY				67,068		67.00
68.00	06800	SPEECH PATHOLOGY				23,438		68.00
69.00	06900	ELECTROCARDIOLOGY				8,864		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY				108,794		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				104,229		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				108,905		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				588,809		73.00
76.00	03190	CHEMOTHERAPY				33,488		76.00
76.01	03020	WOUND CARE				55,185		76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC				0		90.00
90.01	09001	ANDERSON OUTPATIENT CENTER				62,612		90.01
90.02	04950	DIABETIC EDUCATION				0		90.02
90.03	09002	MS CLINIC				0		90.03
91.00	09100	EMERGENCY				416,747		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES				79		95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	5,520,753		118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN				16,014		190.00
191.00	19100	RESEARCH				3,071		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES				95,797		192.00
194.00	07950	FOUNDATION				5,465		194.00
194.01	07951	CHILDRENS CLINIC				1,922		194.01
194.02	07952	PSS ADMINISTRATION				695		194.02
194.03	07953	SEXUAL ASSAULT PROGRAM				62		194.03
194.04	07954	ASPR BIOTERRORISM GRANT				10		194.04
194.05	07955	HEALTHY FAMILIES				97,229		194.05
194.06	07956	DME-HOME CARE				0		194.06
194.07	07957	MARKETING				0		194.07
194.08	07958	CORPORATE COMMUNICATIONS				21,610		194.08

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0088

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Cost Center Description		ALLIED HEALTH-EMS	ALLIED HEALTH-RAD TECH	ALLIED HEALTH-PHARM RESIDENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		23.00	23.01	23.02	24.00	25.00	
194.09	07959 MOB				1,049		0 194.09
194.10	07960 ASC				212		0 194.10
194.11	07961 MAB				0		0 194.11
194.12	07963 ADOLESCENT RESIDENTIAL SERVICES				47,957		0 194.12
194.13	07962 IDLE SPACE				0		0 194.13
200.00	Cross Foot Adjustments	0	4,963	0	4,963		0 200.00
201.00	Negative Cost Centers	0	0	0	14,754		0 201.00
202.00	TOTAL (sum lines 118 through 201)	0	4,963	0	5,831,563		0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet B Part II Date/Time Prepared: 11/29/2022 8:09 am
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MAB	1.01
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
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
23.00	02300	ALLIED HEALTH-EMS	23.00
23.01	02301	ALLIED HEALTH-RAD TECH	23.01
23.02	02303	ALLIED HEALTH-PHARM RESIDENTS	23.02
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03440	MAMMOGRAPHY	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	54.02
54.03	03630	ULTRA SOUND	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03190	CHEMOTHERAPY	76.00
76.01	03020	WOUND CARE	76.01
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	90.01
90.02	04950	DIABETIC EDUCATION	90.02
90.03	09002	MS CLINIC	90.03
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	FOUNDATION	194.00
194.01	07951	CHILDRENS CLINIC	194.01
194.02	07952	PSS ADMINISTRATION	194.02
194.03	07953	SEXUAL ASSAULT PROGRAM	194.03
194.04	07954	ASPR BIOTERRORISM GRANT	194.04
194.05	07955	HEALTHY FAMILIES	194.05
194.06	07956	DME-HOME CARE	194.06
194.07	07957	MARKETING	194.07
194.08	07958	CORPORATE COMMUNICATIONS	194.08
194.09	07959	MOB	194.09
194.10	07960	ASC	194.10
194.11	07961	MAB	194.11
194.12	07963	ADOLESCENT RESIDENTIAL SERVICES	194.12

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet B Part II Date/Time Prepared: 11/29/2022 8:09 am
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Cost Center Description		Total	
		26.00	
194.13	07962 IDLE SPACE	0	194.13
200.00	Cross Foot Adjustments	4,963	200.00
201.00	Negative Cost Centers	14,754	201.00
202.00	TOTAL (sum lines 118 through 201)	5,831,563	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet B-1
Date/Time Prepared:
11/29/2022 8:09 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	BLDG & FIXT-MAB (SQUARE FEET)				
	1.00	1.01				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	471,575				1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT-MAB	0	0			1.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	6,193	0	49,151,840		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	51,875	0	1,633,107	-45,711,820	132,851,431
7.00 00700	OPERATION OF PLANT	55,747	0	0	0	5,363,207
8.00 00800	LAUNDRY & LINEN SERVICE	671	0	0	0	866,618
9.00 00900	HOUSEKEEPING	9,977	0	243	0	2,961,764
10.00 01000	DIETARY	10,309	0	0	0	813,309
11.00 01100	CAFETERIA	17,526	0	0	0	1,949,840
13.00 01300	NURSING ADMINISTRATION	4,884	0	1,785,995	0	2,753,234
14.00 01400	CENTRAL SERVICES & SUPPLY	15,860	0	441,287	0	114,831
15.00 01500	PHARMACY	4,819	0	3,033,348	0	4,224,458
16.00 01600	MEDICAL RECORDS & LIBRARY	5,214	0	0	0	36,219
23.00 02300	ALLIED HEALTH-EMS	0	0	0	0	0
23.01 02301	ALLIED HEALTH-RAD TECH	110	0	102,546	0	154,420
23.02 02303	ALLIED HEALTH-PHARM RESIDENTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	65,475	0	13,327,998	0	19,505,933
31.00 03100	INTENSIVE CARE UNIT	14,660	0	5,082,972	0	8,165,787
41.00 04100	SUBPROVIDER - IRF	10,000	0	1,420,933	0	2,013,307
43.00 04300	NURSERY	6,234	0	222,712	0	351,171
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	47,997	0	700,541	0	13,951,508
52.00 05200	DELIVERY ROOM & LABOR ROOM	22,275	0	947,827	0	1,452,136
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	14,278	0	1,901,455	0	3,346,849
54.01 03440	MAMMOGRAPHY	0	0	269,483	0	578,724
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	1,127	0	285,265	0	980,027
54.03 03630	ULTRA SOUND	0	0	334,662	0	482,156
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	907,496	0	1,980,827
57.00 05700	CT SCAN	551	0	657,510	0	984,792
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,003	0	295,235	0	595,742
59.00 05900	CARDIAC CATHETERIZATION	8,562	0	804,588	0	1,295,370
60.00 06000	LABORATORY	12,544	0	0	0	6,411,676
65.00 06500	RESPIRATORY THERAPY	7,138	0	1,356,138	0	1,870,165
66.00 06600	PHYSICAL THERAPY	9,863	0	1,649,676	0	2,361,778
67.00 06700	OCCUPATIONAL THERAPY	4,441	0	737,790	0	1,054,372
68.00 06800	SPEECH PATHOLOGY	1,553	0	258,046	0	368,770
69.00 06900	ELECTROCARDIOLOGY	0	0	121,063	0	213,028
70.00 07000	ELECTROENCEPHALOGRAPHY	11,644	0	232,743	0	413,432
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,685,468
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,897,421
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	19,644,532
76.00 03190	CHEMOTHERAPY	0	0	763,144	0	1,110,581
76.01 03020	WOUND CARE	3,100	0	437,895	0	1,055,325
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0
90.01 09001	ANDERSON OUTPATIENT CENTER	3,500	0	1,035,156	0	1,291,506
90.02 04950	DIABETIC EDUCATION	0	0	0	0	0
90.03 09002	MS CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	22,635	0	4,594,585	0	7,320,177
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	17,232	0	2,935
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	451,765	0	45,358,671	-45,711,820	127,623,395
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,882	0	0	0	13,071
191.00 19100	RESEARCH	0	0	81,501	0	116,906
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,829	0	2,627,002	0	3,521,653
194.00 07950	FOUNDATION	636	0	0	0	4,417
194.01 07951	CHILDRENS CLINIC	0	0	0	0	214
194.02 07952	PSS ADMINISTRATION	0	0	15,985	0	24,206
194.03 07953	SEXUAL ASSAULT PROGRAM	0	0	1,975	0	2,458
194.04 07954	ASPR BIOTERRORISM GRANT	0	0	0	0	440
194.05 07955	HEALTHY FAMILIES	10,091	0	257,201	0	458,074
194.06 07956	DME-HOME CARE	0	0	0	15,954	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet B-1

Date/Time Prepared:
11/29/2022 8:09 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	BLDG & FIXT-MAB (SQUARE FEET)					
	1.00	1.01	4.00				
194.07 07957 MARKETING	0	0	0	0	0	0	194.07
194.08 07958 CORPORATE COMMUNICATIONS	2,527	0	0	0	0	17,551	194.08
194.09 07959 MOB	0	0	0	0	0	360	194.09
194.10 07960 ASC	0	0	0	0	0	0	194.10
194.11 07961 MAB	0	0	0	0	0	0	194.11
194.12 07963 ADOLESCENT RESIDENTIAL SERVICES	2,845	0	809,505	0	0	1,068,686	194.12
194.13 07962 IDLE SPACE	0	0	0	0	0	0	194.13
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)	3,275,216	0	8,372,818			45,711,820	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	6.945271	0.000000	0.170346			0.344082	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			43,012			2,918,062	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000875			0.021965	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: 15-0088		Period: From 07/01/2021 To 06/30/2022		Worksheet B-1	
Cost Center Description		OPERATION OF PLANT (SQARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (TOTAL HOURS)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MAB					1.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	357,760				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	671	712,365			8.00
9.00	00900	HOUSEKEEPING	9,977	0	69,870		9.00
10.00	01000	DIETARY	10,309	0	630	104,849	10.00
11.00	01100	CAFETERIA	17,526	0	370	0	917,316
13.00	01300	NURSING ADMINISTRATION	4,884	0	250	0	40,591
14.00	01400	CENTRAL SERVICES & SUPPLY	15,860	12,474	830	0	18,863
15.00	01500	PHARMACY	4,819	0	200	0	61,898
16.00	01600	MEDICAL RECORDS & LIBRARY	5,214	0	50	0	0
23.00	02300	ALLIED HEALTH-EMS	0	0	0	0	0
23.01	02301	ALLIED HEALTH-RAD TECH	110	0	0	0	2,712
23.02	02303	ALLIED HEALTH-PHARM RESIDENTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	65,475	262,969	30,921	83,723	278,534
31.00	03100	INTENSIVE CARE UNIT	14,660	77,712	5,500	7,137	77,171
41.00	04100	SUBPROVIDER - IIRF	10,000	27,264	2,500	7,956	26,753
43.00	04300	NURSERY	6,234	5,372	394	0	4,435
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	47,997	113,189	9,200	30	194
52.00	05200	DELIVERY ROOM & LABOR ROOM	22,275	18,209	1,675	1,876	20,107
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,278	1,871	1,750	0	56,973
54.01	03440	MAMMOGRAPHY	0	4,173	150	0	6,221
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	1,127	358	150	0	5,772
54.03	03630	ULTRA SOUND	0	404	0	0	7,045
55.00	05500	RADIOLOGY-THERAPEUTIC	0	9,630	150	0	24,845
57.00	05700	CT SCAN	551	34,855	0	0	15,203
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,003	6,125	150	0	6,162
59.00	05900	CARDIAC CATHETERIZATION	8,562	0	300	92	19,763
60.00	06000	LABORATORY	12,544	0	1,250	0	0
65.00	06500	RESPIRATORY THERAPY	7,138	0	100	0	28,373
66.00	06600	PHYSICAL THERAPY	9,863	7,341	1,306	0	30,092
67.00	06700	OCCUPATIONAL THERAPY	4,441	3,180	588	0	20,813
68.00	06800	SPEECH PATHOLOGY	1,553	616	206	0	7,279
69.00	06900	ELECTROCARDIOLOGY	0	86	1,500	0	3,852
70.00	07000	ELECTROENCEPHALOGRAPHY	11,644	0	700	8	2,132
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03190	CHEMOTHERAPY	0	12,741	0	1,273	24,072
76.01	03020	WOUND CARE	3,100	0	0	0	11,954
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	ANDERSON OUTPATIENT CENTER	3,500	0	600	0	12,406
90.02	04950	DIABETIC EDUCATION	0	0	0	0	0
90.03	09002	MS CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	22,635	103,496	7,050	2,754	83,522
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	337,950	702,065	68,470	104,849	897,737
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,882	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	2,086
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,829	0	0	0	4,148
194.00	07950	FOUNDATION	636	0	25	0	0
194.01	07951	CHILDRENS CLINIC	0	140	900	0	0
194.02	07952	PSS ADMINISTRATION	0	0	0	0	720
194.03	07953	SEXUAL ASSAULT PROGRAM	0	0	0	0	27
194.04	07954	ASPR BIOTERRORISM GRANT	0	0	0	0	0
194.05	07955	HEALTHY FAMILIES	10,091	0	0	0	12,598
194.06	07956	DME-HOME CARE	0	0	0	0	0
194.07	07957	MARKETING	0	0	0	0	0
194.08	07958	CORPORATE COMMUNICATIONS	2,527	0	50	0	0
194.09	07959	MOB	0	10,160	325	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (TOTAL HOURS)	
		7.00	8.00	9.00	10.00	11.00	
194.10	07960 ASC	0	0	100	0	0	194.10
194.11	07961 MAB	0	0	0	0	0	194.11
194.12	07963 ADOLESCENT RESIDENTIAL SERVICES	2,845	0	0	0	0	194.12
194.13	07962 IDLE SPACE	0	0	0	0	0	194.13
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)	7,208,590	1,178,326	4,181,883	1,338,579	2,996,025	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	20.149234	1.654104	59.852340	12.766731	3.266077	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	504,981	24,642	148,431	105,352	190,075	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.411508	0.034592	2.124388	1.004797	0.207208	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: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet B-1
Date/Time Prepared:
11/29/2022 8:09 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	ALLIED HEALTH-EMS (ASSIGNED TIME)		
		13.00	14.00	15.00	16.00	23.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
1.01	00101						1.01	
4.00	00400						4.00	
5.00	00500						5.00	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000						10.00	
11.00	01100						11.00	
13.00	01300	370,642					13.00	
14.00	01400	0	11,731,003				14.00	
15.00	01500	0	159,653	19,644,532			15.00	
16.00	01600	0	6	0	712,688,736		16.00	
23.00	02300	0	0	0	0	0	23.00	
23.01	02301	0	0	0	0	0	23.01	
23.02	02303	0	0	0	0	0	23.02	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	183,168	578,986	0	54,253,345	0	30.00	
31.00	03100	70,247	325,641	0	24,596,779	0	31.00	
41.00	04100	19,168	20,559	0	4,052,273	0	41.00	
43.00	04300	3,723	11,818	0	1,594,912	0	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	15,008	8,594,510	0	132,927,453	0	50.00	
52.00	05200	19,017	74,943	0	4,476,880	0	52.00	
53.00	05300	0	0	0	0	0	53.00	
54.00	05400	0	405,619	0	17,498,630	0	54.00	
54.01	03440	0	61,212	0	3,959,739	0	54.01	
54.02	03450	0	193,698	0	16,696,386	0	54.02	
54.03	03630	0	3,897	0	9,404,689	0	54.03	
55.00	05500	0	16,787	0	30,836,583	0	55.00	
57.00	05700	0	449	0	17,362,629	0	57.00	
58.00	05800	0	1,831	0	2,977,337	0	58.00	
59.00	05900	10,265	169,829	0	24,704,178	0	59.00	
60.00	06000	0	2,840	0	88,218,848	0	60.00	
65.00	06500	0	219,102	0	20,341,215	0	65.00	
66.00	06600	0	50,852	0	8,967,570	0	66.00	
67.00	06700	0	22,900	0	3,707,209	0	67.00	
68.00	06800	0	8,009	0	1,298,172	0	68.00	
69.00	06900	0	1,306	0	1,242,397	0	69.00	
70.00	07000	0	1,537	0	3,992,200	0	70.00	
71.00	07100	0	0	0	21,174,981	0	71.00	
72.00	07200	0	0	0	21,504,051	0	72.00	
73.00	07300	0	0	19,644,532	107,171,213	0	73.00	
76.00	03190	0	108,156	0	8,855,091	0	76.00	
76.01	03020	0	271,118	0	4,974,383	0	76.01	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	0	0	0	0	0	90.00	
90.01	09001	0	566	0	3,845,126	0	90.01	
90.02	04950	0	0	0	0	0	90.02	
90.03	09002	0	0	0	0	0	90.03	
91.00	09100	50,046	424,832	0	72,054,467	0	91.00	
92.00	09200	0	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	0	0	0	0	0	95.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	0	0	0	0	0	113.00	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)						0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	0	0	0	0	0	190.00	
191.00	19100	0	0	0	0	0	191.00	
192.00	19200	0	82	0	0	0	192.00	
194.00	07950	0	0	0	0	0	194.00	
194.01	07951	0	0	0	0	0	194.01	
194.02	07952	0	0	0	0	0	194.02	
194.03	07953	0	0	0	0	0	194.03	
194.04	07954	0	0	0	0	0	194.04	
194.05	07955	0	265	0	0	0	194.05	
194.06	07956	0	0	0	0	0	194.06	
194.07	07957	0	0	0	0	0	194.07	
194.08	07958	0	0	0	0	0	194.08	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet B-1

Date/Time Prepared:
11/29/2022 8:09 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	ALLOCATED HEALTH-EMS (ASSIGNED TIME)	
		13.00	14.00	15.00	16.00	23.00	
194.09	07959 MOB	0	0	0	0	0	194.09
194.10	07960 ASC	0	0	0	0	0	194.10
194.11	07961 MAB	0	0	0	0	0	194.11
194.12	07963 ADOLESCENT RESIDENTIAL SERVICES	0	0	0	0	0	194.12
194.13	07962 IDLE SPACE	0	0	0	0	0	194.13
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)	3,946,517	605,827	5,997,496	156,732	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	10.647787	0.051643	0.305301	0.000220	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	111,795	141,551	150,692	44,475	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.301625	0.010809	0.007671	0.000062	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.000000	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet B-1
Date/Time Prepared:
11/29/2022 8:09 am

Cost Center Description		ALLIED HEALTH-RAD TECH (ASSIGNED TIME)	ALLIED HEALTH-PHARM RESIDENTS (ASSIGNED TIME)	
		23.01	23.02	
GENERAL SERVICE COST CENTERS				
1.00	00100			1.00
1.01	00101			1.01
4.00	00400			4.00
5.00	00500			5.00
7.00	00700			7.00
8.00	00800			8.00
9.00	00900			9.00
10.00	01000			10.00
11.00	01100			11.00
13.00	01300			13.00
14.00	01400			14.00
15.00	01500			15.00
16.00	01600			16.00
23.00	02300			23.00
23.01	02301	98,735,994		23.01
23.02	02303		0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000		0	30.00
31.00	03100		0	31.00
41.00	04100		0	41.00
43.00	04300		0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000		0	50.00
52.00	05200		0	52.00
53.00	05300		0	53.00
54.00	05400	17,498,631	0	54.00
54.01	03440	3,959,739	0	54.01
54.02	03450	16,696,386	0	54.02
54.03	03630	9,404,689	0	54.03
55.00	05500	30,836,583	0	55.00
57.00	05700	17,362,629	0	57.00
58.00	05800	2,977,337	0	58.00
59.00	05900	0	0	59.00
60.00	06000	0	0	60.00
65.00	06500	0	0	65.00
66.00	06600	0	0	66.00
67.00	06700	0	0	67.00
68.00	06800	0	0	68.00
69.00	06900	0	0	69.00
70.00	07000	0	0	70.00
71.00	07100	0	0	71.00
72.00	07200	0	0	72.00
73.00	07300	0	0	73.00
76.00	03190	0	0	76.00
76.01	03020	0	0	76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000		0	90.00
90.01	09001	0	0	90.01
90.02	04950	0	0	90.02
90.03	09002	0	0	90.03
91.00	09100	0	0	91.00
92.00	09200	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500		0	95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300			113.00
118.00		98,735,994	0	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000		0	190.00
191.00	19100		0	191.00
192.00	19200		0	192.00
194.00	07950		0	194.00
194.01	07951		0	194.01
194.02	07952		0	194.02
194.03	07953		0	194.03
194.04	07954		0	194.04
194.05	07955		0	194.05
194.06	07956		0	194.06
194.07	07957		0	194.07
194.08	07958		0	194.08

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet B-1

Date/Time Prepared:
11/29/2022 8:09 am

Cost Center Description		ALLIED HEALTH-RAD TECH (ASSIGNED TIME) 23.01	ALLIED HEALTH-PHARM RESIDENTS (ASSIGNED TIME) 23.02	
194.09	07959 MOB	0	0	194.09
194.10	07960 ASC	0	0	194.10
194.11	07961 MAB	0	0	194.11
194.12	07963 ADOLESCENT RESIDENTIAL SERVICES	0	0	194.12
194.13	07962 IDLE SPACE	0	0	194.13
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)	218,627	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.002214	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	4,963	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000050	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	0	0	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000	0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Prepared: 11/29/2022 8:09 am
			Title XVIII	Hospital	PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
			Total Costs	RCE Disallowance	Total Costs
	1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		33,793,267	0	33,793,267
31.00	03100 INTENSIVE CARE UNIT		12,841,972	0	12,841,972
41.00	04100 SUBPROVIDER - I RF		3,497,270	0	3,497,270
43.00	04300 NURSERY		685,169	0	685,169
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		21,090,795	0	21,090,795
52.00	05200 DELIVERY ROOM & LABOR ROOM		2,827,952	0	2,827,952
53.00	05300 ANESTHESIOLOGY		0	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC		5,143,584	0	5,143,584
54.01	03440 MAMMOGRAPHY		826,851	0	826,851
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC		1,419,009	0	1,419,009
54.03	03630 ULTRA SOUND		694,827	0	694,827
55.00	05500 RADIOLOGY-THERAPEUTIC		2,844,395	0	2,844,395
57.00	05700 CT SCAN		1,484,335	0	1,484,335
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		867,513	0	867,513
59.00	05900 CARDIAC CATHETERIZATION		2,120,785	0	2,120,785
60.00	06000 LABORATORY		8,964,940	0	8,964,940
65.00	06500 RESPIRATORY THERAPY	0	2,771,923	0	2,771,923
66.00	06600 PHYSICAL THERAPY	0	3,566,347	0	3,566,347
67.00	06700 OCCUPATIONAL THERAPY	0	1,617,074	0	1,617,074
68.00	06800 SPEECH PATHOLOGY	0	564,772	0	564,772
69.00	06900 ELECTROCARDIOLOGY		389,169	0	389,169
70.00	07000 ELECTROENCEPHALOGRAPHY		840,224	0	840,224
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		6,302,311	0	6,302,311
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		6,587,266	0	6,587,266
73.00	07300 DRUGS CHARGED TO PATIENTS		32,424,971	0	32,424,971
76.00	03190 CHEMOTHERAPY		1,616,194	0	1,616,194
76.01	03020 WOUND CARE		1,535,044	0	1,535,044
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC		0	0	0
90.01	09001 ANDERSON OUTPATIENT CENTER		1,883,717	0	1,883,717
90.02	04950 DIABETIC EDUCATION		0	0	0
90.03	09002 MS CLINIC		0	0	0
91.00	09100 EMERGENCY		11,766,768	0	11,766,768
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		2,179,223	0	2,179,223
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES		3,945	0	3,945
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				
200.00	Subtotal (see instructions)		173,151,612	0	173,151,612
201.00	Less Observation Beds		2,179,223	0	2,179,223
202.00	Total (see instructions)		170,972,389	0	170,972,389

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0088		Period: From 07/01/2021 To 06/30/2022		Worksheet C Part I Date/Time Prepared: 11/29/2022 8:09 am		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	51,168,757		51,168,757				30.00
31.00	03100	INTENSIVE CARE UNIT	24,596,779		24,596,779				31.00
41.00	04100	SUBPROVIDER - IRF	4,052,273		4,052,273				41.00
43.00	04300	NURSERY	1,594,912		1,594,912				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	23,907,771	109,019,682	132,927,453	0.158664	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,957,078	519,802	4,476,880	0.631679	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,576,936	10,921,694	17,498,630	0.293942	0.000000		54.00
54.01	03440	MAMMOGRAPHY	16,385	3,943,354	3,959,739	0.208815	0.000000		54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	1,265,179	15,431,207	16,696,386	0.084989	0.000000		54.02
54.03	03630	ULTRA SOUND	1,508,740	7,895,949	9,404,689	0.073881	0.000000		54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	249,647	30,586,936	30,836,583	0.092241	0.000000		55.00
57.00	05700	CT SCAN	4,238,881	13,123,748	17,362,629	0.085490	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	706,042	2,271,295	2,977,337	0.291372	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	6,432,905	18,271,273	24,704,178	0.085847	0.000000		59.00
60.00	06000	LABORATORY	33,619,369	54,599,479	88,218,848	0.101622	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	17,482,580	2,858,635	20,341,215	0.136271	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	2,793,843	6,173,727	8,967,570	0.397694	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,895,927	1,811,282	3,707,209	0.436197	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	641,892	656,280	1,298,172	0.435052	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,242,397	1,242,397	0.313240	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	146,766	3,845,434	3,992,200	0.210466	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,235,377	10,939,604	21,174,981	0.297630	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,916,148	17,587,903	21,504,051	0.306327	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,474,831	72,696,382	107,171,213	0.302553	0.000000		73.00
76.00	03190	CHEMOTHERAPY	73,355	8,781,736	8,855,091	0.182516	0.000000		76.00
76.01	03020	WOUND CARE	39,830	4,934,553	4,974,383	0.308590	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0.000000	0.000000		90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	8,699	3,836,427	3,845,126	0.489897	0.000000		90.01
90.02	04950	DIABETIC EDUCATION	0	0	0	0.000000	0.000000		90.02
90.03	09002	MS CLINIC	0	0	0	0.000000	0.000000		90.03
91.00	09100	EMERGENCY	20,493,643	51,560,824	72,054,467	0.163304	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	888,445	2,196,143	3,084,588	0.706488	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000		95.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	256,982,990	455,705,746	712,688,736				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	256,982,990	455,705,746	712,688,736				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Prepared: 11/29/2022 8:09 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.158664		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.631679		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.293942		54.00
54.01	03440 MAMMOGRAPHY	0.208815		54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.084989		54.02
54.03	03630 ULTRA SOUND	0.073881		54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0.092241		55.00
57.00	05700 CT SCAN	0.085490		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.291372		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.085847		59.00
60.00	06000 LABORATORY	0.101622		60.00
65.00	06500 RESPIRATORY THERAPY	0.136271		65.00
66.00	06600 PHYSICAL THERAPY	0.397694		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.436197		67.00
68.00	06800 SPEECH PATHOLOGY	0.435052		68.00
69.00	06900 ELECTROCARDIOLOGY	0.313240		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.210466		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.297630		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.306327		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.302553		73.00
76.00	03190 CHEMOTHERAPY	0.182516		76.00
76.01	03020 WOUND CARE	0.308590		76.01
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 ANDERSON OUTPATIENT CENTER	0.489897		90.01
90.02	04950 DIABETIC EDUCATION	0.000000		90.02
90.03	09002 MS CLINIC	0.000000		90.03
91.00	09100 EMERGENCY	0.163304		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.706488		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Prepared: 11/29/2022 8:09 am
			Title XIX	Hospital	Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
			Total Costs	RCE Disallowance	Total Costs
	1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		33,793,267	0	33,793,267
31.00	03100 INTENSIVE CARE UNIT		12,841,972	0	12,841,972
41.00	04100 SUBPROVIDER - I RF		3,497,270	0	3,497,270
43.00	04300 NURSERY		685,169	0	685,169
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		21,090,795	0	21,090,795
52.00	05200 DELIVERY ROOM & LABOR ROOM		2,827,952	0	2,827,952
53.00	05300 ANESTHESIOLOGY		0	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC		5,143,584	0	5,143,584
54.01	03440 MAMMOGRAPHY		826,851	0	826,851
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC		1,419,009	0	1,419,009
54.03	03630 ULTRA SOUND		694,827	0	694,827
55.00	05500 RADIOLOGY-THERAPEUTIC		2,844,395	0	2,844,395
57.00	05700 CT SCAN		1,484,335	0	1,484,335
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		867,513	0	867,513
59.00	05900 CARDIAC CATHETERIZATION		2,120,785	0	2,120,785
60.00	06000 LABORATORY		8,964,940	0	8,964,940
65.00	06500 RESPIRATORY THERAPY	0	2,771,923	0	2,771,923
66.00	06600 PHYSICAL THERAPY	0	3,566,347	0	3,566,347
67.00	06700 OCCUPATIONAL THERAPY	0	1,617,074	0	1,617,074
68.00	06800 SPEECH PATHOLOGY	0	564,772	0	564,772
69.00	06900 ELECTROCARDIOLOGY		389,169	0	389,169
70.00	07000 ELECTROENCEPHALOGRAPHY		840,224	0	840,224
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		6,302,311	0	6,302,311
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		6,587,266	0	6,587,266
73.00	07300 DRUGS CHARGED TO PATIENTS		32,424,971	0	32,424,971
76.00	03190 CHEMOTHERAPY		1,616,194	0	1,616,194
76.01	03020 WOUND CARE		1,535,044	0	1,535,044
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC		0	0	0
90.01	09001 ANDERSON OUTPATIENT CENTER		1,883,717	0	1,883,717
90.02	04950 DIABETIC EDUCATION		0	0	0
90.03	09002 MS CLINIC		0	0	0
91.00	09100 EMERGENCY		11,766,768	0	11,766,768
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		2,179,223	0	2,179,223
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES		3,945	0	3,945
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				
200.00	Subtotal (see instructions)		173,151,612	0	173,151,612
201.00	Less Observation Beds		2,179,223	0	2,179,223
202.00	Total (see instructions)		170,972,389	0	170,972,389

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0088		Period: From 07/01/2021 To 06/30/2022		Worksheet C Part I Date/Time Prepared: 11/29/2022 8:09 am		
			Title XIX			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	51,168,757		51,168,757				30.00
31.00	03100	INTENSIVE CARE UNIT	24,596,779		24,596,779				31.00
41.00	04100	SUBPROVIDER - IRF	4,052,273		4,052,273				41.00
43.00	04300	NURSERY	1,594,912		1,594,912				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	23,907,771	109,019,682	132,927,453	0.158664	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,957,078	519,802	4,476,880	0.631679	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,576,936	10,921,694	17,498,630	0.293942	0.000000		54.00
54.01	03440	MAMMOGRAPHY	16,385	3,943,354	3,959,739	0.208815	0.000000		54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	1,265,179	15,431,207	16,696,386	0.084989	0.000000		54.02
54.03	03630	ULTRA SOUND	1,508,740	7,895,949	9,404,689	0.073881	0.000000		54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	249,647	30,586,936	30,836,583	0.092241	0.000000		55.00
57.00	05700	CT SCAN	4,238,881	13,123,748	17,362,629	0.085490	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	706,042	2,271,295	2,977,337	0.291372	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	6,432,905	18,271,273	24,704,178	0.085847	0.000000		59.00
60.00	06000	LABORATORY	33,619,369	54,599,479	88,218,848	0.101622	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	17,482,580	2,858,635	20,341,215	0.136271	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	2,793,843	6,173,727	8,967,570	0.397694	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,895,927	1,811,282	3,707,209	0.436197	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	641,892	656,280	1,298,172	0.435052	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,242,397	1,242,397	0.313240	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	146,766	3,845,434	3,992,200	0.210466	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,235,377	10,939,604	21,174,981	0.297630	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,916,148	17,587,903	21,504,051	0.306327	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,474,831	72,696,382	107,171,213	0.302553	0.000000		73.00
76.00	03190	CHEMOTHERAPY	73,355	8,781,736	8,855,091	0.182516	0.000000		76.00
76.01	03020	WOUND CARE	39,830	4,934,553	4,974,383	0.308590	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0.000000	0.000000		90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	8,699	3,836,427	3,845,126	0.489897	0.000000		90.01
90.02	04950	DIABETIC EDUCATION	0	0	0	0.000000	0.000000		90.02
90.03	09002	MS CLINIC	0	0	0	0.000000	0.000000		90.03
91.00	09100	EMERGENCY	20,493,643	51,560,824	72,054,467	0.163304	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	888,445	2,196,143	3,084,588	0.706488	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000		95.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	256,982,990	455,705,746	712,688,736				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	256,982,990	455,705,746	712,688,736				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Prepared: 11/29/2022 8:09 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03440 MAMMOGRAPHY	0.000000		54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.000000		54.02
54.03	03630 ULTRA SOUND	0.000000		54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
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
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
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
76.00	03190 CHEMOTHERAPY	0.000000		76.00
76.01	03020 WOUND CARE	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 ANDERSON OUTPATIENT CENTER	0.000000		90.01
90.02	04950 DIABETIC EDUCATION	0.000000		90.02
90.03	09002 MS CLINIC	0.000000		90.03
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part I Date/Time Prepared: 11/29/2022 8:09 am
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)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,268,770	0	1,268,770	24,346	52.11	30.00
31.00	INTENSIVE CARE UNIT	370,087	0	370,087	5,098	72.59	31.00
41.00	SUBPROVIDER - IRF	155,079	0	155,079	2,221	69.82	41.00
43.00	NURSERY	63,296		63,296	674	93.91	43.00
200.00	Total (lines 30 through 199)	1,857,232		1,857,232	32,339		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	3,638	189,576				
31.00	INTENSIVE CARE UNIT	3,281	238,168				
41.00	SUBPROVIDER - IRF	835	58,300				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	7,754	486,044				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part II Date/Time Prepared: 11/29/2022 8:09 am
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Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	837,635	132,927,453	0.006301	8,860,803	55,832	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	235,935	4,476,880	0.052701	7,129	376	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	215,554	17,498,630	0.012318	1,418,090	17,468	54.00
54.01	03440	MAMMOGRAPHY	15,608	3,959,739	0.003942	0	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	35,850	16,696,386	0.002147	435,962	936	54.02
54.03	03630	ULTRA SOUND	12,983	9,404,689	0.001380	0	0	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	52,196	30,836,583	0.001693	128,941	218	55.00
57.00	05700	CT SCAN	32,248	17,362,629	0.001857	1,183,360	2,197	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	23,738	2,977,337	0.007973	183,350	1,462	58.00
59.00	05900	CARDIAC CATHETERIZATION	111,995	24,704,178	0.004533	1,647,093	7,466	59.00
60.00	06000	LABORATORY	253,815	88,218,848	0.002877	8,922,712	25,671	60.00
65.00	06500	RESPIRATORY THERAPY	111,635	20,341,215	0.005488	4,532,805	24,876	65.00
66.00	06600	PHYSICAL THERAPY	146,111	8,967,570	0.016293	599,958	9,775	66.00
67.00	06700	OCCUPATIONAL THERAPY	67,068	3,707,209	0.018091	302,066	5,465	67.00
68.00	06800	SPEECH PATHOLOGY	23,438	1,298,172	0.018055	134,790	2,434	68.00
69.00	06900	ELECTROCARDIOLOGY	8,864	1,242,397	0.007135	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	108,794	3,992,200	0.027252	55,191	1,504	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	104,229	21,174,981	0.004922	2,477,548	12,194	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	108,905	21,504,051	0.005064	2,527,952	12,802	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	588,809	107,171,213	0.005494	8,475,943	46,567	73.00
76.00	03190	CHEMOTHERAPY	33,488	8,855,091	0.003782	0	0	76.00
76.01	03020	WOUND CARE	55,185	4,974,383	0.011094	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	62,612	3,845,126	0.016283	0	0	90.01
90.02	04950	DIABETIC EDUCATION	0	0	0.000000	0	0	90.02
90.03	09002	MS CLINIC	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	416,747	72,054,467	0.005784	5,001,840	28,931	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	81,819	3,084,588	0.026525	501,385	13,299	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	3,745,261	631,276,015		47,396,918	269,473	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part III Date/Time Prepared: 11/29/2022 8:09 am
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Cost Center Description		Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
		1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	200.00
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
		4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	24,346	0.00	3,638 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	5,098	0.00	3,281 31.00
41.00	04100	SUBPROVIDER - IRF	0	0	2,221	0.00	835 41.00
43.00	04300	NURSERY	0	0	674	0.00	0 43.00
200.00		Total (lines 30 through 199)	0	0	32,339		7,754 200.00
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
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: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Prepared: 11/29/2022 8:09 am
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Cost Center Description	Title XVIII			Hospital		Total
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	38,742	54.00
54.01 03440 MAMMOGRAPHY	0	0	0	0	8,767	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	36,966	54.02
54.03 03630 ULTRA SOUND	0	0	0	0	20,822	54.03
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	68,297	55.00
57.00 05700 CT SCAN	0	0	0	0	38,441	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	6,592	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
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.00 03190 CHEMOTHERAPY	0	0	0	0	0	76.00
76.01 03020 WOUND CARE	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 ANDERSON OUTPATIENT CENTER	0	0	0	0	0	90.01
90.02 04950 DIABETIC EDUCATION	0	0	0	0	0	90.02
90.03 09002 MS CLINIC	0	0	0	0	0	90.03
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00 Total (lines 50 through 199)	0	0	0	0	218,627	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Prepared: 11/29/2022 8:09 am
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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)	Title XVIII	
						Hospital	PPS
	4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	0	132,927,453	0.000000		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	4,476,880	0.000000		52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0.000000		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	38,742	38,742	17,498,630	0.002214		54.00
54.01 03440 MAMMOGRAPHY	0	8,767	8,767	3,959,739	0.002214		54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	36,966	36,966	16,696,386	0.002214		54.02
54.03 03630 ULTRA SOUND	0	20,822	20,822	9,404,689	0.002214		54.03
55.00 05500 RADIOLOGY-THERAPEUTIC	0	68,297	68,297	30,836,583	0.002215		55.00
57.00 05700 CT SCAN	0	38,441	38,441	17,362,629	0.002214		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	6,592	6,592	2,977,337	0.002214		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	24,704,178	0.000000		59.00
60.00 06000 LABORATORY	0	0	0	88,218,848	0.000000		60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	20,341,215	0.000000		65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	8,967,570	0.000000		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	3,707,209	0.000000		67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	1,298,172	0.000000		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	1,242,397	0.000000		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	3,992,200	0.000000		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	21,174,981	0.000000		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,504,051	0.000000		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	107,171,213	0.000000		73.00
76.00 03190 CHEMOTHERAPY	0	0	0	8,855,091	0.000000		76.00
76.01 03020 WOUND CARE	0	0	0	4,974,383	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	0	0	0	0.000000		90.00
90.01 09001 ANDERSON OUTPATIENT CENTER	0	0	0	3,845,126	0.000000		90.01
90.02 04950 DIABETIC EDUCATION	0	0	0	0	0.000000		90.02
90.03 09002 MS CLINIC	0	0	0	0	0.000000		90.03
91.00 09100 EMERGENCY	0	0	0	72,054,467	0.000000		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,084,588	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES							95.00
200.00 Total (lines 50 through 199)	0	218,627	218,627	631,276,015			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Prepared: 11/29/2022 8:09 am
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Cost Center Description		Title XVIII				Hospital	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PPS
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	8,860,803	0	22,546,383	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	7,129	0	2,065	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.002214	1,418,090	3,140	3,348,835	7,414	54.00
54.01	03440 MAMMOGRAPHY	0.002214	0	0	0	0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.002214	435,962	965	4,225,797	9,356	54.02
54.03	03630 ULTRA SOUND	0.002214	0	0	0	0	54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0.002215	128,941	286	10,678,867	23,654	55.00
57.00	05700 CT SCAN	0.002214	1,183,360	2,620	2,504,444	5,545	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.002214	183,350	406	473,626	1,049	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	1,647,093	0	3,834,469	0	59.00
60.00	06000 LABORATORY	0.000000	8,922,712	0	5,104,262	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	4,532,805	0	621,341	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	599,958	0	55,442	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	302,066	0	10,511	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	134,790	0	120,664	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	55,191	0	708,689	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,477,548	0	2,246,010	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,527,952	0	4,086,304	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	8,475,943	0	23,027,333	0	73.00
76.00	03190 CHEMOTHERAPY	0.000000	0	0	6,221	0	76.00
76.01	03020 WOUND CARE	0.000000	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	09001 ANDERSON OUTPATIENT CENTER	0.000000	0	0	199,329	0	90.01
90.02	04950 DIABETIC EDUCATION	0.000000	0	0	0	0	90.02
90.03	09002 MS CLINIC	0.000000	0	0	0	0	90.03
91.00	09100 EMERGENCY	0.000000	5,001,840	0	7,464,809	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	501,385	0	1,880,574	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		47,396,918	7,417	93,145,975	47,018	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Prepared: 11/29/2022 8:09 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.158664	22,546,383	0	0	3,577,299	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.631679	2,065	0	0	1,304	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.293942	3,348,835	0	0	984,363	54.00
54.01 03440 MAMMOGRAPHY	0.208815	0	0	0	0	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.084989	4,225,797	0	0	359,146	54.02
54.03 03630 ULTRA SOUND	0.073881	0	0	0	0	54.03
55.00 05500 RADIOLOGY-THERAPEUTIC	0.092241	10,678,867	0	0	985,029	55.00
57.00 05700 CT SCAN	0.085490	2,504,444	0	0	214,105	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.291372	473,626	0	0	138,001	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.085847	3,834,469	0	0	329,178	59.00
60.00 06000 LABORATORY	0.101622	5,104,262	0	0	518,705	60.00
65.00 06500 RESPIRATORY THERAPY	0.136271	621,341	0	0	84,671	65.00
66.00 06600 PHYSICAL THERAPY	0.397694	55,442	0	0	22,049	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.436197	10,511	0	0	4,585	67.00
68.00 06800 SPEECH PATHOLOGY	0.435052	120,664	0	0	52,495	68.00
69.00 06900 ELECTROCARDIOLOGY	0.313240	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.210466	708,689	0	0	149,155	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.297630	2,246,010	0	0	668,480	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.306327	4,086,304	0	0	1,251,745	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.302553	23,027,333	0	13,631	6,966,989	73.00
76.00 03190 CHEMOTHERAPY	0.182516	6,221	0	0	1,135	76.00
76.01 03020 WOUND CARE	0.308590	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.000000	0	0	0	0	90.00
90.01 09001 ANDERSON OUTPATIENT CENTER	0.489897	199,329	0	0	97,651	90.01
90.02 04950 DIABETIC EDUCATION	0.000000	0	0	0	0	90.02
90.03 09002 MS CLINIC	0.000000	0	0	0	0	90.03
91.00 09100 EMERGENCY	0.163304	7,464,809	0	0	1,219,033	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.706488	1,880,574	0	0	1,328,603	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
200.00	Subtotal (see instructions)	93,145,975	0	13,631	18,953,721	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0	0	201.00
202.00	Net Charges (line 200 - line 201)	93,145,975	0	13,631	18,953,721	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Prepared: 11/29/2022 8:09 am
Title XVIII		Hospital	PPS

Cost Center Description	Costs		Hospital	PPS
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 03440 MAMMOGRAPHY	0	0		54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0		54.02
54.03 03630 ULTRA SOUND	0	0		54.03
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
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
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
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	4,124		73.00
76.00 03190 CHEMOTHERAPY	0	0		76.00
76.01 03020 WOUND CARE	0	0		76.01
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 ANDERSON OUTPATIENT CENTER	0	0		90.01
90.02 04950 DIABETIC EDUCATION	0	0		90.02
90.03 09002 MS CLINIC	0	0		90.03
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
200.00 Subtotal (see instructions)	0	4,124		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	4,124		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part II Date/Time Prepared: 11/29/2022 8:09 am
		Component CCN: 15-T088		
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	837,635	132,927,453	0.006301	26,457	167	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	235,935	4,476,880	0.052701	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	215,554	17,498,630	0.012318	39,506	487	54.00
54.01	03440 MAMMOGRAPHY	15,608	3,959,739	0.003942	0	0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	35,850	16,696,386	0.002147	3,667	8	54.02
54.03	03630 ULTRA SOUND	12,983	9,404,689	0.001380	0	0	54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	52,196	30,836,583	0.001693	0	0	55.00
57.00	05700 CT SCAN	32,248	17,362,629	0.001857	19,550	36	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	23,738	2,977,337	0.007973	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	111,995	24,704,178	0.004533	4,451	20	59.00
60.00	06000 LABORATORY	253,815	88,218,848	0.002877	348,322	1,002	60.00
65.00	06500 RESPIRATORY THERAPY	111,635	20,341,215	0.005488	107,303	589	65.00
66.00	06600 PHYSICAL THERAPY	146,111	8,967,570	0.016293	384,508	6,265	66.00
67.00	06700 OCCUPATIONAL THERAPY	67,068	3,707,209	0.018091	398,806	7,215	67.00
68.00	06800 SPEECH PATHOLOGY	23,438	1,298,172	0.018055	92,913	1,678	68.00
69.00	06900 ELECTROCARDIOLOGY	8,864	1,242,397	0.007135	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	108,794	3,992,200	0.027252	4,631	126	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	104,229	21,174,981	0.004922	55,443	273	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	108,905	21,504,051	0.005064	4,861	25	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	588,809	107,171,213	0.005494	173,693	954	73.00
76.00	03190 CHEMOTHERAPY	33,488	8,855,091	0.003782	0	0	76.00
76.01	03020 WOUND CARE	55,185	4,974,383	0.011094	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.01	09001 ANDERSON OUTPATIENT CENTER	62,612	3,845,126	0.016283	0	0	90.01
90.02	04950 DIABETIC EDUCATION	0	0	0.000000	0	0	90.02
90.03	09002 MS CLINIC	0	0	0.000000	0	0	90.03
91.00	09100 EMERGENCY	416,747	72,054,467	0.005784	32,905	190	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3,084,588	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	3,663,442	631,276,015		1,697,016	19,035	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0088 Component CCN: 15-T088	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Prepared: 11/29/2022 8:09 am
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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	38,742	54.00
54.01	03440	MAMMOGRAPHY	0	0	0	0	8,767	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	36,966	54.02
54.03	03630	ULTRA SOUND	0	0	0	0	20,822	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	68,297	55.00
57.00	05700	CT SCAN	0	0	0	0	38,441	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	6,592	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
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.00	03190	CHEMOTHERAPY	0	0	0	0	0	76.00
76.01	03020	WOUND CARE	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	0	0	0	0	0	90.01
90.02	04950	DIABETIC EDUCATION	0	0	0	0	0	90.02
90.03	09002	MS CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	218,627	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0088 Component CCN: 15-T088	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Prepared: 11/29/2022 8:09 am
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Title XVIII		Subprovider - IRF	PPS
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col.s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col.s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7) (see instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	132,927,453	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	4,476,880	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	38,742	38,742	17,498,630	0.002214	54.00
54.01 03440 MAMMOGRAPHY	0	8,767	8,767	3,959,739	0.002214	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	36,966	36,966	16,696,386	0.002214	54.02
54.03 03630 ULTRA SOUND	0	20,822	20,822	9,404,689	0.002214	54.03
55.00 05500 RADIOLOGY-THERAPEUTIC	0	68,297	68,297	30,836,583	0.002215	55.00
57.00 05700 CT SCAN	0	38,441	38,441	17,362,629	0.002214	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	6,592	6,592	2,977,337	0.002214	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	24,704,178	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	88,218,848	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	20,341,215	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	8,967,570	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	3,707,209	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	1,298,172	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	1,242,397	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	3,992,200	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	21,174,981	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,504,051	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	107,171,213	0.000000	73.00
76.00 03190 CHEMOTHERAPY	0	0	0	8,855,091	0.000000	76.00
76.01 03020 WOUND CARE	0	0	0	4,974,383	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0.000000	90.00
90.01 09001 ANDERSON OUTPATIENT CENTER	0	0	0	3,845,126	0.000000	90.01
90.02 04950 DIABETIC EDUCATION	0	0	0	0	0.000000	90.02
90.03 09002 MS CLINIC	0	0	0	0	0.000000	90.03
91.00 09100 EMERGENCY	0	0	0	72,054,467	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,084,588	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	218,627	218,627	631,276,015		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0088 Component CCN: 15-T088	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Prepared: 11/29/2022 8:09 am
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Title XVIII		Subprovider - IRF	PPS
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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	26,457	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.002214	39,506	87	0	0	54.00
54.01	03440 MAMMOGRAPHY	0.002214	0	0	0	0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.002214	3,667	8	0	0	54.02
54.03	03630 ULTRA SOUND	0.002214	0	0	0	0	54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0.002215	0	0	0	0	55.00
57.00	05700 CT SCAN	0.002214	19,550	43	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.002214	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	4,451	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	348,322	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	107,303	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	384,508	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	398,806	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	92,913	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	4,631	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	55,443	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,861	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	173,693	0	0	0	73.00
76.00	03190 CHEMOTHERAPY	0.000000	0	0	0	0	76.00
76.01	03020 WOUND CARE	0.000000	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	09001 ANDERSON OUTPATIENT CENTER	0.000000	0	0	0	0	90.01
90.02	04950 DIABETIC EDUCATION	0.000000	0	0	0	0	90.02
90.03	09002 MS CLINIC	0.000000	0	0	0	0	90.03
91.00	09100 EMERGENCY	0.000000	32,905	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		1,697,016	138	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Prepared: 11/29/2022 8:09 am
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		Title XIX		Hospital		Cost	
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.158664	0	1,206,129	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.631679	0	5,325	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.293942	0	264,865	0	0	54.00
54.01	03440 MAMMOGRAPHY	0.208815	0	8,396	0	0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.084989	0	92,708	0	0	54.02
54.03	03630 ULTRA SOUND	0.073881	0	139,021	0	0	54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0.092241	0	855,940	0	0	55.00
57.00	05700 CT SCAN	0.085490	0	303,491	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.291372	0	22,759	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.085847	0	316,850	0	0	59.00
60.00	06000 LABORATORY	0.101622	0	1,057,664	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.136271	0	66,005	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.397694	0	59,753	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.436197	0	27,015	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.435052	0	9,449	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.313240	0	833	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.210466	0	32,192	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.297630	0	51,460	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.306327	0	230,762	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.302553	0	771,729	0	0	73.00
76.00	03190 CHEMOTHERAPY	0.182516	0	149,073	0	0	76.00
76.01	03020 WOUND CARE	0.308590	0	220,965	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	09001 ANDERSON OUTPATIENT CENTER	0.489897	0	147,870	0	0	90.01
90.02	04950 DIABETIC EDUCATION	0.000000	0	0	0	0	90.02
90.03	09002 MS CLINIC	0.000000	0	0	0	0	90.03
91.00	09100 EMERGENCY	0.163304	0	1,831,783	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.706488	0	92,605	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
200.00	Subtotal (see instructions)		0	7,964,642	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 - line 201)		0	7,964,642	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Prepared: 11/29/2022 8:09 am
	Title XIX	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	191,369	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3,364	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	77,855	0		54.00
54.01 03440 MAMMOGRAPHY	1,753	0		54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	7,879	0		54.02
54.03 03630 ULTRA SOUND	10,271	0		54.03
55.00 05500 RADIOLOGY-THERAPEUTIC	78,953	0		55.00
57.00 05700 CT SCAN	25,945	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	6,631	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	27,201	0		59.00
60.00 06000 LABORATORY	107,482	0		60.00
65.00 06500 RESPIRATORY THERAPY	8,995	0		65.00
66.00 06600 PHYSICAL THERAPY	23,763	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	11,784	0		67.00
68.00 06800 SPEECH PATHOLOGY	4,111	0		68.00
69.00 06900 ELECTROCARDIOLOGY	261	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	6,775	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15,316	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	70,689	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	233,489	0		73.00
76.00 03190 CHEMOTHERAPY	27,208	0		76.00
76.01 03020 WOUND CARE	68,188	0		76.01
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 ANDERSON OUTPATIENT CENTER	72,441	0		90.01
90.02 04950 DIABETIC EDUCATION	0	0		90.02
90.03 09002 MS CLINIC	0	0		90.03
91.00 09100 EMERGENCY	299,137	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	65,424	0		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
200.00 Subtotal (see instructions)	1,446,284	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)	1,446,284	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepared: 11/29/2022 8:09 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		24,346	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		24,346	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)		22,776	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)		3,638	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)		33,793,267	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)		33,793,267	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)		33,793,267	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)		1,388.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,049,690	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)		5,049,690	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0088		Period: From 07/01/2021 To 06/30/2022		Worksheet D-1 Date/Time Prepared: 11/29/2022 8:09 am	
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)	
Title XVIII		1.00	2.00	3.00	4.00	5.00	
Hospital							
PPS							
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	12,841,972	5,098	2,519.02	3,281	8,264,905	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					9,384,449	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					22,699,044	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)					427,744	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					276,890	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					704,634	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					21,994,410	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)					1,570	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,388.04	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,179,223	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0088		Period: From 07/01/2021 To 06/30/2022		Worksheet D-1 Date/Time Prepared: 11/29/2022 8:09 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,268,770	33,793,267	0.037545	2,179,223	81,819	90.00
91.00	Nursing Program cost	0	33,793,267	0.000000	2,179,223	0	91.00
92.00	Allied health cost	0	33,793,267	0.000000	2,179,223	0	92.00
93.00	All other Medical Education	0	33,793,267	0.000000	2,179,223	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1
		Component CCN: 15-T088		Date/Time Prepared: 11/29/2022 8:09 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,221	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,221	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)		2,221	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)		835	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,497,270	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,497,270	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,497,270	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)		1,574.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,314,824	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)		1,314,824	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0088		Period: From 07/01/2021 To 06/30/2022		Worksheet D-1	
		Component CCN: 15-T088				Date/Time Prepared: 11/29/2022 8:09 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					512,382		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,827,206		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)					58,300		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					19,173		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					77,473		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,749,733		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: 15-0088 Component CCN: 15-T088		Period: From 07/01/2021 To 06/30/2022		Worksheet D-1 Date/Time Prepared: 11/29/2022 8:09 am	
		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	155,079	3,497,270	0.044343	0	0	90.00
91.00	Nursing Program cost	0	3,497,270	0.000000	0	0	91.00
92.00	Allied health cost	0	3,497,270	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,497,270	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepared: 11/29/2022 8:09 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			24,346 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			24,346 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)			22,776 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)			985 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)			674 15.00
16.00	Nursery days (title V or XIX only)			553 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)			33,793,267 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)			33,793,267 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)			33,793,267 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)			1,388.04 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,367,219 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)			1,367,219 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0088		Period: From 07/01/2021 To 06/30/2022		Worksheet D-1 Date/Time Prepared: 11/29/2022 8:09 am	
Cost Center Description			Title XIX		Hospital		Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)			
42.00	NURSERY (title V & XIX only)	685,169	674	1,016.57	553	562,163		42.00
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	12,841,972	5,098	2,519.02	198	498,766		43.00
44.00	CORONARY CARE UNIT							44.00
45.00	BURN INTENSIVE CARE UNIT							45.00
46.00	SURGICAL INTENSIVE CARE UNIT							46.00
47.00	OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description								
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,619,478		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,047,626		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)					1,570		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,388.04		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,179,223		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0088		Period: From 07/01/2021 To 06/30/2022		Worksheet D-1 Date/Time Prepared: 11/29/2022 8:09 am	
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	1,268,770	33,793,267	0.037545	2,179,223	81,819	90.00
91.00	Nursing Program cost	0	33,793,267	0.000000	2,179,223	0	91.00
92.00	Allied health cost	0	33,793,267	0.000000	2,179,223	0	92.00
93.00	All other Medical Education	0	33,793,267	0.000000	2,179,223	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1
		Component CCN: 15-T088		Date/Time Prepared: 11/29/2022 8:09 am
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,221	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,221	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)		2,221	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)		67	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)		674	15.00
16.00	Nursery days (title V or XIX only)		553	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,497,270	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,497,270	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,497,270	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)		1,574.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		105,501	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)		105,501	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0088		Period: From 07/01/2021 To 06/30/2022		Worksheet D-1	
		Component CCN: 15-T088				Date/Time Prepared: 11/29/2022 8:09 am	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					38,908		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					144,409		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: 15-0088 Component CCN: 15-T088		Period: From 07/01/2021 To 06/30/2022		Worksheet D-1 Date/Time Prepared: 11/29/2022 8:09 am	
		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	155,079	3,497,270	0.044343	0	0	90.00
91.00	Nursing Program cost	0	3,497,270	0.000000	0	0	91.00
92.00	Allied health cost	0	3,497,270	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,497,270	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet D-3 Date/Time Prepared: 11/29/2022 8:09 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		12,253,954	30.00
31.00	03100	INTENSIVE CARE UNIT		5,660,810	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.158664	8,860,803	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.631679	7,129	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.293942	1,418,090	54.00
54.01	03440	MAMMOGRAPHY	0.208815	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.084989	435,962	54.02
54.03	03630	ULTRA SOUND	0.073881	0	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0.092241	128,941	55.00
57.00	05700	CT SCAN	0.085490	1,183,360	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.291372	183,350	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.085847	1,647,093	59.00
60.00	06000	LABORATORY	0.101622	8,922,712	60.00
65.00	06500	RESPIRATORY THERAPY	0.136271	4,532,805	65.00
66.00	06600	PHYSICAL THERAPY	0.397694	599,958	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.436197	302,066	67.00
68.00	06800	SPEECH PATHOLOGY	0.435052	134,790	68.00
69.00	06900	ELECTROCARDIOLOGY	0.313240	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.210466	55,191	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.297630	2,477,548	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.306327	2,527,952	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.302553	8,475,943	73.00
76.00	03190	CHEMOTHERAPY	0.182516	0	76.00
76.01	03020	WOUND CARE	0.308590	0	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	0.489897	0	90.01
90.02	04950	DIABETIC EDUCATION	0.000000	0	90.02
90.03	09002	MS CLINIC	0.000000	0	90.03
91.00	09100	EMERGENCY	0.163304	5,001,840	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.706488	501,385	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		47,396,918	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)		47,396,918	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0088 Component CCN: 15-T088	Period: From 07/01/2021 To 06/30/2022	Worksheet D-3 Date/Time Prepared: 11/29/2022 8:09 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVIDER - IRF			1,466,068	41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.158664	26,457	4,198	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.631679	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.293942	39,506	11,612	54.00
54.01	03440 MAMMOGRAPHY	0.208815	0	0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.084989	3,667	312	54.02
54.03	03630 ULTRA SOUND	0.073881	0	0	54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0.092241	0	0	55.00
57.00	05700 CT SCAN	0.085490	19,550	1,671	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.291372	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.085847	4,451	382	59.00
60.00	06000 LABORATORY	0.101622	348,322	35,397	60.00
65.00	06500 RESPIRATORY THERAPY	0.136271	107,303	14,622	65.00
66.00	06600 PHYSICAL THERAPY	0.397694	384,508	152,917	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.436197	398,806	173,958	67.00
68.00	06800 SPEECH PATHOLOGY	0.435052	92,913	40,422	68.00
69.00	06900 ELECTROCARDIOLOGY	0.313240	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.210466	4,631	975	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.297630	55,443	16,502	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.306327	4,861	1,489	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.302553	173,693	52,551	73.00
76.00	03190 CHEMOTHERAPY	0.182516	0	0	76.00
76.01	03020 WOUND CARE	0.308590	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 ANDERSON OUTPATIENT CENTER	0.489897	0	0	90.01
90.02	04950 DIABETIC EDUCATION	0.000000	0	0	90.02
90.03	09002 MS CLINIC	0.000000	0	0	90.03
91.00	09100 EMERGENCY	0.163304	32,905	5,374	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.706488	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,697,016	512,382	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,697,016		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet D-3 Date/Time Prepared: 11/29/2022 8:09 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		3,089,543	30.00
31.00	03100	INTENSIVE CARE UNIT		834,321	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		149,722	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.158664	1,234,566	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.631679	153,789	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.293942	346,342	54.00
54.01	03440	MAMMOGRAPHY	0.208815	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.084989	55,349	54.02
54.03	03630	ULTRA SOUND	0.073881	103,567	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0.092241	0	55.00
57.00	05700	CT SCAN	0.085490	237,881	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.291372	42,963	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.085847	312,939	59.00
60.00	06000	LABORATORY	0.101622	1,901,051	60.00
65.00	06500	RESPIRATORY THERAPY	0.136271	756,271	65.00
66.00	06600	PHYSICAL THERAPY	0.397694	73,766	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.436197	46,844	67.00
68.00	06800	SPEECH PATHOLOGY	0.435052	4,646	68.00
69.00	06900	ELECTROCARDIOLOGY	0.313240	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.210466	18,613	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.297630	393,825	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.306327	87,824	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.302553	1,281,596	73.00
76.00	03190	CHEMOTHERAPY	0.182516	138	76.00
76.01	03020	WOUND CARE	0.308590	489	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	0.489897	137	90.01
90.02	04950	DIABETIC EDUCATION	0.000000	0	90.02
90.03	09002	MS CLINIC	0.000000	0	90.03
91.00	09100	EMERGENCY	0.163304	1,644,220	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.706488	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		8,696,816	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		8,696,816	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0088 Component CCN: 15-T088	Period: From 07/01/2021 To 06/30/2022	Worksheet D-3 Date/Time Prepared: 11/29/2022 8:09 am
		Title XIX	Subprovider - IRF	Cost
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF		119,038	41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.158664	223	35 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.631679	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.293942	1,414	416 54.00
54.01	03440 MAMMOGRAPHY	0.208815	0	0 54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.084989	0	0 54.02
54.03	03630 ULTRA SOUND	0.073881	0	0 54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0.092241	0	0 55.00
57.00	05700 CT SCAN	0.085490	850	73 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.291372	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.085847	0	0 59.00
60.00	06000 LABORATORY	0.101622	34,022	3,457 60.00
65.00	06500 RESPIRATORY THERAPY	0.136271	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.397694	30,257	12,033 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.436197	32,639	14,237 67.00
68.00	06800 SPEECH PATHOLOGY	0.435052	11,738	5,107 68.00
69.00	06900 ELECTROCARDIOLOGY	0.313240	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.210466	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.297630	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.306327	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.302553	11,734	3,550 73.00
76.00	03190 CHEMOTHERAPY	0.182516	0	0 76.00
76.01	03020 WOUND CARE	0.308590	0	0 76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000	0	0 90.00
90.01	09001 ANDERSON OUTPATIENT CENTER	0.489897	0	0 90.01
90.02	04950 DIABETIC EDUCATION	0.000000	0	0 90.02
90.03	09002 MS CLINIC	0.000000	0	0 90.03
91.00	09100 EMERGENCY	0.163304	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.706488	0	0 92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		122,877	38,908 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net charges (line 200 minus line 201)		122,877	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part A Date/Time Prepared: 11/29/2022 8:09 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		2,808,431	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		8,932,787	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)		189,008	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		876,838	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		139.09	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)		7.67	30.00
31.00	Percentage of Medicaid patient days (see instructions)		32.05	31.00
32.00	Sum of lines 30 and 31		39.72	32.00
33.00	Allowable disproportionate share percentage (see instructions)		21.98	33.00
34.00	Disproportionate share adjustment (see instructions)		645,180	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part A Date/Time Prepared: 11/29/2022 8:09 am
		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)	8,290,014,521	7,192,008,710	35.00
35.01	Factor 3 (see instructions)	0.000362241	0.000310627	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	3,002,983	2,234,030	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	756,917	1,670,932	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,427,849		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)	15,880,093		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)		15,880,093	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		976,506	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		26,096	53.00
54.00	Special add-on payments for new technologies		592,302	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		7,417	58.00
59.00	Total (sum of amounts on lines 49 through 58)		17,482,414	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		17,482,414	61.00
62.00	Deductibles billed to program beneficiaries		1,360,452	62.00
63.00	Coinsurance billed to program beneficiaries		73,951	63.00
64.00	Allowable bad debts (see instructions)		187,966	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		122,178	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		65,362	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		16,170,189	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		4,106	70.93
70.94	HRR adjustment amount (see instructions)		-3,491	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part A Date/Time Prepared: 11/29/2022 8:09 am
		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)		16,170,804	71.00
71.01	Sequestration adjustment (see instructions)		40,427	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		15,340,197	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)		790,180	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		350,911	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)			90.00
91.00	Capital outlier from Wkst. L, Pt. 1, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. 11, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/29/2022 8:09 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,808,431	0	2,808,431		2,808,431	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	8,932,787	0		8,932,787	8,932,787	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	189,008	0	189,008		189,008	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	876,838	0		876,838	876,838	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2198	0.2198	0.2198	0.2198		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	645,180	0	154,323	490,857	645,180	11.00
11.01	Uncompensated care payments	36.00	2,427,849	0	321,525	870,488	1,192,013	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	15,880,093	0	3,473,287	12,406,806	15,880,093	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	15,880,093	0	3,473,287	12,406,806	15,880,093	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	976,506	0	236,701	739,805	976,506	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/29/2022 8:09 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	592,302	0	100,920	491,382	592,302	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	3,810,908	13,637,993	17,448,901	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	882,187	0	215,268	666,919	882,187	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	20,480	0	3,415	17,065	20,480	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0837	0.0837	0.0837	0.0837		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	73,839	0	18,018	55,821	73,839	25.00
26.00	Total prospective capital payments (see instructions)	12.00	976,506	0	236,701	739,805	976,506	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0088		Period: From 07/01/2021 To 06/30/2022		Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/29/2022 8:09 am	
		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,808,431	2,808,431		2,808,431	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	8,932,787		8,932,787	8,932,787	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	189,008	189,008		189,008	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	876,838		876,838	876,838	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2198	0.2198	0.2198		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	645,180	154,323	490,857	645,180	11.00
11.01	Uncompensated care payments	36.00	2,427,849	466,425	1,821,010	2,287,435	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	15,880,093	3,618,187	12,261,906	15,880,093	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	15,880,093	3,618,187	12,261,906	15,880,093	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	976,506	236,701	739,805	976,506	16.00
17.00	Special add-on payments for new technologies	54.00	592,302	100,920	491,382	592,302	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			3,955,808	13,493,093	17,448,901	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/29/2022 8:09 am
Title XVIII		Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	882,187	215,268	666,919	882,187	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	20,480	3,415	17,065	20,480	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0837	0.0837	0.0837		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	73,839	18,018	55,821	73,839	25.00
26.00	Total prospective capital payments (see instructions)	12.00	976,506	236,701	739,805	976,506	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	4,106	4,106	0	4,106	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-3,491	-3,491	0	-3,491	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part B Date/Time Prepared: 11/29/2022 8:09 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,124	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		18,906,703	2.00
3.00	OPPS payments		14,406,534	3.00
4.00	Outlier payment (see instructions)		96,096	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		47,018	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		4,124	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		13,631	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)		13,631	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		13,631	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		9,507	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)		4,124	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)		14,549,648	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)		2,742,784	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)		11,810,988	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)		11,810,988	30.00
31.00	Primary payer payments		1,626	31.00
32.00	Subtotal (line 30 minus line 31)		11,809,362	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)		289,670	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		188,286	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		114,099	36.00
37.00	Subtotal (see instructions)		11,997,648	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-15	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		11,997,663	40.00
40.01	Sequestration adjustment (see instructions)		29,994	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		12,119,166	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-151,497	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		10,000	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: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part B Date/Time Prepared: 11/29/2022 8:09 am
Title XVIII		Hospital	PPS
			1.00
200.00	MEDI CARE PART B ANCI LLARY COSTS Part B Combined Billed Days		0 200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet E-1
Part I
Date/Time Prepared:
11/29/2022 8:09 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		15,340,197		12,119,166	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)		15,340,197		12,119,166	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		790,180		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		151,497	6.02	
7.00	Total Medicare program liability (see instructions)		16,130,377		11,967,669	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: 15-0088 Component CCN: 15-T088	Period: From 07/01/2021 To 06/30/2022	Worksheet E-1 Part I Date/Time Prepared: 11/29/2022 8:09 am	
		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				0
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,540,270		0
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				0
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,540,270		0
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				0
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				0
6.01	SETTLEMENT TO PROVIDER		14,013		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		1,554,283		0
				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				0

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet E-1 Part II Date/Time Prepared: 11/29/2022 8:09 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (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: 15-0088 Component CCN: 15-T088	Period: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part III Date/Time Prepared: 11/29/2022 8:09 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			1,462,083 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0198 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			109,802 3.00
4.00	Outlier Payments			0 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)			6.084932 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)			1,571,885 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			1,571,885 17.00
18.00	Primary payer payments			1,202 18.00
19.00	Subtotal (line 17 less line 18).			1,570,683 19.00
20.00	Deductibles			9,048 20.00
21.00	Subtotal (line 19 minus line 20)			1,561,635 21.00
22.00	Coinsurance			5,446 22.00
23.00	Subtotal (line 21 minus line 22)			1,556,189 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			2,848 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			1,851 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,484 26.00
27.00	Subtotal (sum of lines 23 and 25)			1,558,040 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)			138 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)			1,558,178 32.00
32.01	Sequestration adjustment (see instructions)			3,895 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			1,540,270 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)			14,013 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			16,083 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			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: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part VII Date/Time Prepared: 11/29/2022 8:09 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		4,047,626		1.00
2.00	Medical and other services			1,446,284	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		4,047,626	1,446,284	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)		4,047,626	1,446,284	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		10,846,386		8.00
9.00	Ancillary service charges		8,696,816	7,964,642	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)		19,543,202	7,964,642	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)		19,543,202	7,964,642	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		15,495,576	6,518,358	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)		4,047,626	1,446,284	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)		4,047,626	1,446,284	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)		4,047,626	1,446,284	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		4,047,626	1,446,284	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		4,047,626	1,446,284	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		4,047,626	1,446,284	40.00
41.00	Interim payments		4,047,626	1,446,284	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0088 Component CCN: 15-T088	Period: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part VII Date/Time Prepared: 11/29/2022 8:09 am
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	144,409		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)	144,409	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)	144,409	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	702,264		8.00
9.00	Ancillary service charges	122,877	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)	825,141	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)	825,141	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	680,732	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)	144,409	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	144,409	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)	144,409	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	144,409	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	144,409	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	144,409	0	40.00
41.00	Interim payments	144,409	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet E-4 Date/Time Prepared: 11/29/2022 8:09 am
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Title XVIII		Hospital	PPS
			1.00

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

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

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

		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	7,754	7,641		26.00
27.00	Total Inpatient Days (see instructions)	30,214	30,214		27.00
28.00	Ratio of inpatient days to total inpatient days	0.256636	0.252896		28.00
29.00	Program direct GME amount	0	0	0	29.00
29.01	Percent reduction for MA DGME				29.01
30.00	Reduction for direct GME payments for Medicare Advantage		0	0	30.00
31.00	Net Program direct GME amount			0	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet E-4 Date/Time Prepared: 11/29/2022 8:09 am	
		Title XVIII	Hospital	PPS	
				1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)					
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			24,526,250	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			1,202	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			24,525,048	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			18,957,845	42.00
43.00	Primary payer payments (see instructions)			1,626	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			18,956,219	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			43,481,267	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.564037	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.435963	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			0	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			0	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			0	50.00
		Y/N	Primary Care	Other	Total
		0	1.00	2.00	3.00
E-4 Calculation - In accordance with the FY 2023 IPPS Final Rule.					
109.00	Enter in column 0, "Y" or "N" to calculate line 9 in accordance the Federal Fiscal Year 2023 Final Rule for cost reporting periods beginning prior to 10/1/2021. (see instructions)	N	0.00	0.00	0.00
If line 109 column 0 is Y, you MUST open up the PY and Penultimate cost reports and answer line 109 column 0 "Y" and calculate, then input amounts from line 11 columns 1 & 2 to the CY lines 12 & 13 columns 1 & 2 respectively.					
122.00	Override of line 22 for cost reporting periods beginning prior to 10/1/2021. (see instructions)		0.00		122.00

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

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet G
Date/Time Prepared:
11/29/2022 8:09 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	13,689	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	69,886,872	0	0	0	4.00
5.00	Other receivable	691,446	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-43,570,621	0	0	0	6.00
7.00	Inventory	4,263,464	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,703,599	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	32,988,449	0	0	0	11.00
FIXED ASSETS						
12.00	Land	5,292,602	0	0	0	12.00
13.00	Land improvements	2,926,142	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	111,552,556	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	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	62,828,972	0	0	0	23.00
24.00	Accumulated depreciation	-128,274,381	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	54,325,891	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,459,289	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,459,289	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	88,773,629	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	5,176,700	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,571,348	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	217,695	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	38,828,175	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	49,793,918	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	13,459,249	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	614,054	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	14,073,303	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	63,867,221	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	24,906,408	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	24,906,408	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	88,773,629	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet G-1

Date/Time Prepared:
11/29/2022 8:09 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		19,382,754		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		11,476,955			2.00
3.00	Total (sum of line 1 and line 2)		30,859,709		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		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)		30,859,709		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00	MISCELLANEOUS	5,953,301		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		5,953,301		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		24,906,408		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	Deductions (debit adjustments) (specify)		0			12.00
13.00	MISCELLANEOUS		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: 15-0088

Period:
From 07/01/2021
To 06/30/2022

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/29/2022 8:09 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	54,816,614		54,816,614	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	3,945,532		3,945,532	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)	58,762,146		58,762,146	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	23,292,102		23,292,102	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	23,292,102		23,292,102	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	82,054,248		82,054,248	17.00
18.00	Ancillary services	177,197,954	400,089,555	577,287,509	18.00
19.00	Outpatient services	0	58,476,943	58,476,943	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
27.01	OTHER (SPECIFY)	0	0	0	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	259,252,202	458,566,498	717,818,700	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		192,399,858		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		192,399,858		43.00

STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet G-3 Date/Time Prepared: 11/29/2022 8:09 am
			1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)		717,818,700	1.00
2.00	Less contractual allowances and discounts on patients' accounts		517,988,087	2.00
3.00	Net patient revenues (line 1 minus line 2)		199,830,613	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)		192,399,858	4.00
5.00	Net income from service to patients (line 3 minus line 4)		7,430,755	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		333,616	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		1,702	17.00
18.00	Revenue from sale of medical records and abstracts		55,281	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		34,336	21.00
22.00	Rental of hospital space		609,621	22.00
23.00	Governmental appropriations		0	23.00
24.00	LAB SERVICE REVENUE		0	24.00
24.01	SHARED REVENUE		288,064	24.01
24.02	OTHER (SPECIFY)		0	24.02
24.03	GRANTS REVENUE		283,849	24.03
24.04	MISC REVENUE		739,491	24.04
24.05	SCHOOL OF RAD TECH		18,525	24.05
24.06	OTHER (SPECIFY)		0	24.06
24.07	CONTRACT SERVICE REVENUE		22,739	24.07
24.08	OTHER (SPECIFY)		0	24.08
24.09	RESEARCH REVENUE		45,230	24.09
24.10	ASSETS RELEASED FROM RESTRICTED FUND		38,056	24.10
24.11	GAIN ON DISPOSAL OF ASSET		23,124	24.11
24.50	COVID-19 PHE Funding		1,552,965	24.50
25.00	Total other income (sum of lines 6-24)		4,046,599	25.00
26.00	Total (line 5 plus line 25)		11,477,354	26.00
27.00	EHR		0	27.00
27.01	RESTRUCTURING EXPENSE		0	27.01
27.02	FUND RAISING ACTIVITIES		0	27.02
27.03	OTHER EXPENSES		399	27.03
28.00	Total other expenses (sum of line 27 and subscripts)		399	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)		11,476,955	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet L Parts I-III Date/Time Prepared: 11/29/2022 8:09 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		882,187	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		20,480	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)		77.03	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)		7.67	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		32.05	8.00
9.00	Sum of lines 7 and 8		39.72	9.00
10.00	Allowable disproportionate share percentage (see instructions)		8.37	10.00
11.00	Disproportionate share adjustment (see instructions)		73,839	11.00
12.00	Total prospective capital payments (see instructions)		976,506	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