

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: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet S Parts I-III Date/Time Prepared: 11/21/2022 9:16 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report 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.	Date: 11/21/2022 Time: 9:16 am
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 CARMEL (15-0157) 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 to be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Becky Jacobson		2
3	Signatory Title	VP - FINANCE		3
4	Date	11/21/2022 09:16:28 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	307,266	51,191	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
200.00 Total	0	307,266	51,191	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: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part I Date/Time Prepared: 11/21/2022 9:16 am
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1.00	2.00	3.00	4.00	
Hospital and Hospital Health Care Complex Address:				
1.00	Street: 13500 NORTH MERIDIAN STREET		PO Box:	1.00
2.00	City: CARMEL	State: IN	Zip Code: 46033	County: HAMILTON

	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 CARMEL	150157	26900	1	01/14/2004	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									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)				Y	Y			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N	N		22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N	N		22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				3	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0157			Period: From 07/01/2021 To 06/30/2022		Worksheet S-2 Part I Date/Time Prepared: 11/21/2022 9:16 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.	601	508	8	12	3,475	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00	
						Urban/Rural	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.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00

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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.		N				60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00		2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovi- der Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

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			1.00	
Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00
TEFRA Providers				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00
			V 1.00	XIX 2.00
Title V and XIX Services				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y 90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Y 91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N 92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N 93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N 94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00 95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N 96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00 97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		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	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N	
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	
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	
			Physical 1.00	Occupational 2.00
			Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N 109.00
			1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N 110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part I Date/Time Prepared: 11/21/2022 9:16 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		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	889,173
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H046	140.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0157		Period: From 07/01/2021 To 06/30/2022		Worksheet S-2 Part II Date/Time Prepared: 11/21/2022 9:16 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				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
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.	N					7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				Y		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/06/2022	Y	10/06/2022		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part II Date/Time Prepared: 11/21/2022 9:16 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		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				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				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.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				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.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				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.				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.	JOHN		KUHN	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.	317-583-3236		JOHN.KUHN@STVINCENT.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part II Date/Time Prepared: 11/21/2022 9:16 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.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0157

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

Worksheet S-3
Part I
Date/Time Prepared:
11/21/2022 9:16 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	96	35,040	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)		96	35,040	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	10	3,650	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 NEONATAL INTENSIVE CARE UNIT	35.00	15	5,475	0.00	0	12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		121	44,165	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						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)		121				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: 15-0157

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

Worksheet S-3
Part I
Date/Time Prepared:
11/21/2022 9:16 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)	3,444	306	14,866			1.00
2.00 HMO and other (see instructions)	2,980	3,495				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	3,444	306	14,866			7.00
8.00 INTENSIVE CARE UNIT	1,221	161	2,281			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 NEONATAL INTENSIVE CARE UNIT	0	558	2,339			12.00
13.00 NURSERY		81	3,046			13.00
14.00 Total (see instructions)	4,665	1,106	22,532	0.00	456.52	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						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)			0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	456.52	27.00
28.00 Observation Bed Days		0	2,576			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			867			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	3	1,020			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: 15-0157

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

Worksheet S-3
Part I
Date/Time Prepared:
11/21/2022 9:16 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	1,036	88	7,060	1.00
2.00 HMO and other (see instructions)				565	925		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 NEONATAL INTENSIVE CARE UNIT							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	1,036	88		7,060	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							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: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part II Date/Time Prepared: 11/21/2022 9:16 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	41,558,289	-154,708	41,403,581	898,309.55	46.09
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		31,063	0	31,063	220.97	140.58
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		2,210	0	2,210	17.10	129.24
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		77,074	0	77,074	1,369.38	56.28
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		563,842	0	563,842	8,590.17	65.64
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		541,400	6,806	548,206	13,223.90	41.46
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		2,354,124	0	2,354,124	19,680.49	119.62
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		1,387,791	0	1,387,791	22,014.18	63.04
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		7,881,157	0	7,881,157	156,035.36	50.51
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		11,545,644	-154,708	11,390,936		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		357,862	0	357,862		
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		8,716	0	8,716		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		634	0	634		
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)		2,999,429	0	2,999,429		
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: 15-0157

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

Worksheet S-3
Part II
Date/Time Prepared:
11/21/2022 9:16 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)	0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	864,751	-864,751	0	0.00	0.00	26.00
27.00	Administrative & General	1,609,395	5,410	1,614,805	21,363.49	75.59	27.00
28.00	Administrative & General under contract (see inst.)	833,363	0	833,363	7,679.82	108.51	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	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)	1,656,549	0	1,656,549	58,678.61	28.23	33.00
34.00	Dietary	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)	698,524	0	698,524	22,710.86	30.76	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	2,026,896	49,461	2,076,357	41,547.23	49.98	38.00
39.00	Central Services and Supply	450,788	8,666	459,454	19,520.73	23.54	39.00
40.00	Pharmacy	2,119,530	36,386	2,155,916	43,046.08	50.08	40.00
41.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	41.00
42.00	Social Service	64,531	1,241	65,772	2,241.57	29.34	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0157

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

Worksheet S-3
Part III
Date/Time Prepared:
11/21/2022 9:16 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)	44,103,599	-154,708	43,948,891	977,402.19	44.97	1.00
2.00	Excluded area salaries (see instructions)	541,400	6,806	548,206	13,223.90	41.46	2.00
3.00	Subtotal salaries (line 1 minus line 2)	43,562,199	-161,514	43,400,685	964,178.29	45.01	3.00
4.00	Subtotal other wages & related costs (see inst.)	11,623,072	0	11,623,072	197,730.03	58.78	4.00
5.00	Subtotal wage-related costs (see inst.)	14,553,789	-154,708	14,399,081	0.00	33.18	5.00
6.00	Total (sum of lines 3 thru 5)	69,739,060	-316,222	69,422,838	1,161,908.32	59.75	6.00
7.00	Total overhead cost (see instructions)	10,324,327	-763,587	9,560,740	216,788.39	44.10	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part IV Date/Time Prepared: 11/21/2022 9:16 am
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		1,533,615	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		184,856	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)		5,100,487	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		1,545,698	9.00
10.00	Dental, Hearing and Vision Plan		107,606	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		-9,282	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		258,103	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		112,728	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		3,011,009	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		796	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		59,801	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		7,440	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		11,912,857	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: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part V Date/Time Prepared: 11/21/2022 9:16 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		2,354,124	11,912,857
2.00	Hospital		2,354,124	11,912,857
3.00	SUBPROVIDER - IPF			
4.00	SUBPROVIDER - IRF			
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: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet S-10 Date/Time Prepared: 11/21/2022 9:16 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)		0.168537	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		7,463,109	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		113,757,438	6.00	
7.00	Medicaid cost (line 1 times line 6)		19,172,337	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)		11,709,228	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)		11,709,228	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)	7,341,227	1,323,648	8,664,875	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,237,268	1,323,648	2,560,916	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)	1,237,268	1,323,648	2,560,916	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)			7,345,482	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			95,014	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			146,175	27.01
28.00	Non-Medicare bad debt expense (see instructions)			7,199,307	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,264,511	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			3,825,427	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			15,534,655	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0157

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

Worksheet A
Date/Time Prepared: 11/21/2022 9:16 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		23,706,233	23,706,233	-3,666	23,702,567	1.00
2.00	00200		4,449,829	4,449,829	0	4,449,829	2.00
4.00	00400	864,751	7,074,196	7,938,947	-809,151	7,129,796	4.00
5.00	00500	1,609,395	35,725,734	37,335,129	10,238	37,345,367	5.00
7.00	00700	0	4,706,428	4,706,428	0	4,706,428	7.00
8.00	00800	0	668,534	668,534	0	668,534	8.00
9.00	00900	0	2,175,807	2,175,807	0	2,175,807	9.00
10.00	01000	0	2,091,760	2,091,760	-900,572	1,191,188	10.00
11.00	01100	0	10,215	10,215	900,572	910,787	11.00
13.00	01300	2,026,896	285,526	2,312,422	51,829	2,364,251	13.00
14.00	01400	450,788	44,920	495,708	8,666	504,374	14.00
15.00	01500	2,119,530	87,608	2,207,138	40,745	2,247,883	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	64,531	52,564	117,095	1,241	118,336	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	10,005,326	2,895,697	12,901,023	-1,078,728	11,822,295	30.00
31.00	03100	2,378,039	851,991	3,230,030	45,804	3,275,834	31.00
35.00	02060	1,854,130	540,028	2,394,158	35,643	2,429,801	35.00
43.00	04300	0	0	0	1,312,926	1,312,926	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	4,148,642	6,291,336	10,439,978	80,307	10,520,285	50.00
52.00	05200	2,994,745	2,395,376	5,390,121	57,528	5,447,649	52.00
54.00	05400	1,958,150	812,788	2,770,938	37,643	2,808,581	54.00
54.01	03480	0	0	0	0	0	54.01
54.02	05402	208,545	20,923	229,468	4,009	233,477	54.02
57.00	05700	689,288	182,935	872,223	13,251	885,474	57.00
58.00	05800	302,342	151,965	454,307	5,812	460,119	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	3,605,158	3,605,158	0	3,605,158	60.00
65.00	06500	1,328,488	254,691	1,583,179	25,538	1,608,717	65.00
66.00	06600	554,138	58,064	612,202	10,653	622,855	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	16,872	5,873	22,745	324	23,069	68.00
69.00	06900	144,282	30,681	174,963	2,774	177,737	69.00
70.00	07000	4,534	2,855	7,389	87	7,476	70.00
71.00	07100	0	4,731,624	4,731,624	0	4,731,624	71.00
72.00	07200	0	5,272,505	5,272,505	0	5,272,505	72.00
73.00	07300	0	5,587,537	5,587,537	0	5,587,537	73.00
75.00	07500	3,235,131	7,327,343	10,562,474	62,191	10,624,665	75.00
76.00	03330	2,270,662	2,120,230	4,390,892	43,651	4,434,543	76.00
76.01	03020	25,343	2,961	28,304	0	28,304	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	1,762,341	1,064,537	2,826,878	33,879	2,860,757	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		41,016,889	125,286,452	166,303,341	-6,806	166,296,535	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	134,719	321,656	456,375	2,590	458,965	190.00
192.00	19200	406,681	70,257	476,938	4,216	481,154	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
194.04	07954	0	0	0	0	0	194.04
194.06	07956	0	33,571	33,571	0	33,571	194.06
200.00		41,558,289	125,711,936	167,270,225	0	167,270,225	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0157

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

Worksheet A
Date/Time Prepared:
11/21/2022 9:16 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	-16,970,386	6,732,181	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-391,873	4,057,956	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	289,962	7,419,758	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-10,858,689	26,486,678	5.00
7.00	00700	OPERATION OF PLANT	-7,757	4,698,671	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	668,534	8.00
9.00	00900	HOUSEKEEPING	0	2,175,807	9.00
10.00	01000	DIETARY	-1,456	1,189,732	10.00
11.00	01100	CAFETERIA	-334,038	576,749	11.00
13.00	01300	NURSING ADMINISTRATION	-98,954	2,265,297	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-720,894	-216,520	14.00
15.00	01500	PHARMACY	-99	2,247,784	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	118,336	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-542,234	11,280,061	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,275,834	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	-10,914	2,418,887	35.00
43.00	04300	NURSERY	0	1,312,926	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-3,322	10,516,963	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-1,098,818	4,348,831	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-127,093	2,681,488	54.00
54.01	03480	ONCOLOGY	0	0	54.01
54.02	05402	ULTRASOUND	0	233,477	54.02
57.00	05700	CT SCAN	-44,150	841,324	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-14,423	445,696	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	3,605,158	60.00
65.00	06500	RESPIRATORY THERAPY	-282	1,608,435	65.00
66.00	06600	PHYSICAL THERAPY	-38	622,817	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	23,069	68.00
69.00	06900	ELECTROCARDIOLOGY	0	177,737	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,476	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,731,624	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,272,505	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,587,537	73.00
75.00	07500	ASC (NON-DISTINCT PART)	-1,069,833	9,554,832	75.00
76.00	03330	ENDOSCOPY	-9,152	4,425,391	76.00
76.01	03020	WOUND CARE	0	28,304	76.01
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	2,860,757	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-32,014,443	134,282,092	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	458,965	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	481,154	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	194.00
194.01	07951	MARKETING	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	194.02
194.04	07954	SCHOOL NURSE	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	33,571	194.06
200.00		TOTAL (SUM OF LINES 118 through 199)	-32,014,443	135,255,782	200.00

RECLASSIFICATIONS

Provider CCN: 15-0157

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

Worksheet A-6
Date/Time Prepared:
11/21/2022 9:16 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - NURSERY RECLASS						
1.00	NURSERY	43.00	1,113,586	199,340	1.00	
	O		1,113,586	199,340		
B - PTO ACCRUAL						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	55,093	1.00	
	O		0	55,093		
C - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	0	900,572	1.00	
	O		0	900,572		
F - INTEREST RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,666	1.00	
	O		0	3,666		
G - NONPHYSICIAN STARP RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	16,554	0	1.00	
2.00	NURSING ADMINISTRATION	13.00	37,090	0	2.00	
3.00	CENTRAL SERVICES & SUPPLY	14.00	8,666	0	3.00	
4.00	PHARMACY	15.00	40,745	0	4.00	
5.00	SOCIAL SERVICE	17.00	1,241	0	5.00	
6.00	ADULTS & PEDIATRICS	30.00	194,213	0	6.00	
7.00	INTENSIVE CARE UNIT	31.00	45,715	0	7.00	
8.00	NEONATAL INTENSIVE CARE UNIT	35.00	35,643	0	8.00	
9.00	OPERATING ROOM	50.00	79,752	0	9.00	
10.00	DELIVERY ROOM & LABOR ROOM	52.00	57,528	0	10.00	
11.00	RADIOLOGY-DIAGNOSTIC	54.00	37,643	0	11.00	
12.00	ULTRASOUND	54.02	4,009	0	12.00	
13.00	CT SCAN	57.00	13,251	0	13.00	
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	5,812	0	14.00	
15.00	RESPIRATORY THERAPY	65.00	25,538	0	15.00	
16.00	PHYSICAL THERAPY	66.00	10,653	0	16.00	
17.00	SPEECH PATHOLOGY	68.00	324	0	17.00	
18.00	ELECTROCARDIOLOGY	69.00	2,774	0	18.00	
19.00	ELECTROENCEPHALOGRAPHY	70.00	87	0	19.00	
20.00	ASC (NON-DISTINCT PART)	75.00	62,191	0	20.00	
21.00	ENDOSCOPY	76.00	43,651	0	21.00	
22.00	EMERGENCY	91.00	33,879	0	22.00	
23.00	GI FT, FLOWER, COFFEE SHOP & CANTEEN	190.00	2,590	0	23.00	
24.00	PHYSICIANS' PRIVATE OFFICES	192.00	4,216	0	24.00	
	O		763,765	0		
H - SEVERANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	45,893	0	1.00	
	O		45,893	0		
I - SYSTEM PROJECT (SITTERS) RECLASS						
1.00	NURSING ADMINISTRATION	13.00	14,739	0	1.00	
2.00	ADULTS & PEDIATRICS	30.00	39,985	0	2.00	
3.00	INTENSIVE CARE UNIT	31.00	89	0	3.00	
4.00	OPERATING ROOM	50.00	555	0	4.00	
5.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	507	5.00	
	O		55,368	507		
L - FURLOUGH (SCK) RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,669	1.00	
2.00	NURSING ADMINISTRATION	13.00	0	2,368	2.00	
3.00	PHARMACY	15.00	0	4,359	3.00	
4.00	ADULTS & PEDIATRICS	30.00	0	30,710	4.00	
5.00	INTENSIVE CARE UNIT	31.00	0	2,876	5.00	
6.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	7,529	6.00	
7.00	OPERATING ROOM	50.00	0	16,229	7.00	
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	13,814	8.00	
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8,435	9.00	
10.00	CT SCAN	57.00	0	4,610	10.00	
11.00	RESPIRATORY THERAPY	65.00	0	2,195	11.00	
12.00	PHYSICAL THERAPY	66.00	0	325	12.00	
13.00	ENDOSCOPY	76.00	0	2,949	13.00	
14.00	EMERGENCY	91.00	0	1,547	14.00	
	O		0	99,615		
500.00	Grand Total: Increases		1,978,612	1,258,793	500.00	

RECLASSIFICATIONS

Provider CCN: 15-0157

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

Worksheet A-6

Date/Time Prepared:
11/21/2022 9:16 am

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	1,113,586	199,340	0	1.00
	O		1,113,586	199,340		
B - PTO ACCRUAL						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	55,093	0	0	1.00
	O		55,093	0		
C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	0	900,572	0	1.00
	O		0	900,572		
F - INTEREST RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,666	11	1.00
	O		0	3,666		
G - NONPHYSICIAN STARP RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	763,765	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
	O		763,765	0		
H - SEVERANCE RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	45,893	0	0	1.00
	O		45,893	0		
I - SYSTEM PROJECT (SITTERS) RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	55,368	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	ADMINISTRATIVE & GENERAL	5.00	0	507	0	5.00
	O		55,368	507		
L - FURLOUGH (SCK) RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	1,669	0	0	1.00
2.00	NURSING ADMINISTRATION	13.00	2,368	0	0	2.00
3.00	PHARMACY	15.00	4,359	0	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	30,710	0	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	2,876	0	0	5.00
6.00	NEONATAL INTENSIVE CARE UNIT	35.00	7,529	0	0	6.00
7.00	OPERATING ROOM	50.00	16,229	0	0	7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	13,814	0	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	8,435	0	0	9.00
10.00	CT SCAN	57.00	4,610	0	0	10.00
11.00	RESPIRATORY THERAPY	65.00	2,195	0	0	11.00
12.00	PHYSICAL THERAPY	66.00	325	0	0	12.00
13.00	ENDOSCOPY	76.00	2,949	0	0	13.00
14.00	EMERGENCY	91.00	1,547	0	0	14.00
	O		99,615	0		
500.00	Grand Total: Decreases		2,133,320	1,104,085		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0157

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

Worksheet A-7
Part I
Date/Time Prepared:
11/21/2022 9:16 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	15,676,014	0	0	0	114,258	1.00
2.00	Land Improvements	3,511,485	892,653	0	892,653	0	2.00
3.00	Buildings and Fixtures	87,542,306	3,504,478	0	3,504,478	0	3.00
4.00	Building Improvements	3,288,035	0	0	0	5,829	4.00
5.00	Fixed Equipment	18,566,156	728,704	0	728,704	0	5.00
6.00	Movable Equipment	54,127,003	4,288,136	0	4,288,136	-11,865	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	182,710,999	9,413,971	0	9,413,971	108,222	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	182,710,999	9,413,971	0	9,413,971	108,222	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	15,561,756	0				1.00
2.00	Land Improvements	4,404,138	0				2.00
3.00	Buildings and Fixtures	91,046,784	0				3.00
4.00	Building Improvements	3,282,206	0				4.00
5.00	Fixed Equipment	19,294,860	0				5.00
6.00	Movable Equipment	58,427,004	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	192,016,748	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	192,016,748	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0157

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

Worksheet A-7
Part II
Date/Time Prepared:
11/21/2022 9:16 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	3,591,439	3,726,611	16,189,779	0	198,404	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,387,289	1,049,508	0	0	10,253	2.00
3.00	Total (sum of lines 1-2)	6,978,728	4,776,119	16,189,779	0	208,657	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	23,706,233				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,779	4,449,829				2.00
3.00	Total (sum of lines 1-2)	2,779	28,156,062				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0157

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

Worksheet A-7
Part III
Date/Time Prepared:
11/21/2022 9:16 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	106,817,527	0	106,817,527	0.587831	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	74,897,129	0	74,897,129	0.412169	0	2.00
3.00	Total (sum of lines 1-2)	181,714,656	0	181,714,656	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	3,591,439	3,726,611	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,995,416	1,049,508	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,586,855	4,776,119	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	-3,665	0	198,404	-780,608	6,732,181	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	10,253	2,779	4,057,956	2.00
3.00	Total (sum of lines 1-2)	-3,665	0	208,657	-777,829	10,790,137	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0157

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

Worksheet A-8

Date/Time Prepared:
11/21/2022 9:16 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.	Ref.
				Cost Center	Line #		
				1.00	2.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-709,085	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2.00		2.00
3.00	Investment income - other (chapter 2)	B	-56,575	ADMINISTRATIVE & GENERAL	5.00		3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00		4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00		5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00		6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00		7.00
8.00	Television and radio service (chapter 21)	A	-5,425	OPERATION OF PLANT	7.00		8.00
9.00	Parking lot (chapter 21)		0		0.00		9.00
10.00	Provider-based physician adjustment	A-8-2	-1,625,215				10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00		11.00
12.00	Related organization transactions (chapter 10)	A-8-1	3,733,629				12.00
13.00	Laundry and linen service		0		0.00		13.00
14.00	Cafeteria-employees and guests	B	-329,133	CAFETERIA	11.00		14.00
15.00	Rental of quarters to employee and others		0		0.00		15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00		16.00
17.00	Sale of drugs to other than patients	B	0	PHARMACY	15.00		17.00
18.00	Sale of medical records and abstracts		0		0.00		18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00		19.00
20.00	Vending machines	B	-1,456	DIETARY	10.00		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		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		26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00		27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00		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
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		32.00
33.00	DONATIONS MADE	A	0	ADMINISTRATIVE & GENERAL	5.00		33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0157

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

Worksheet A-8

Date/Time Prepared:
11/21/2022 9:16 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	
33.01 BILLING ARRANGEMENTS	B	-1,414,344	ADMINISTRATIVE & GENERAL		5.00	0 33.01
33.02 VENDING - CAFE	B	-4,905	CAFETERIA		11.00	0 33.02
33.03 MEALS ON WHEELS	B		DIETARY		10.00	0 33.03
34.00 ON SITE CLINICS OTHER REVENUE	B	-101,336	ADULTS & PEDIATRICS		30.00	0 34.00
35.00 CONSOLIDATING ENTRY	B	-1,230,509	ADMINISTRATIVE & GENERAL		5.00	0 35.00
36.00 PATIENT INTEREST INCOME - A&G	B	-147	ADMINISTRATIVE & GENERAL		5.00	0 36.00
37.00 PATIENT INTEREST INCOME - ENDO	B	-8,298	ENDOSCOPY		76.00	0 37.00
37.01 PATIENT INTEREST INCOME - ASC	B	-11,986	ASC (NON-DISTINCT PART)		75.00	0 37.01
37.02 PATIENT INTEREST INCOME - ROUTINE	B		ADULTS & PEDIATRICS		30.00	0 37.02
37.03 OTHER MISC REVENUE - SURGERY	B	-700	OPERATING ROOM		50.00	0 37.03
38.00 OTHER MISC REVENUE - NURS ADMIN	B	-22,577	NURSING ADMINISTRATION		13.00	0 38.00
38.01 OTHER MISC REVENUE - ROUTINE	B	-120	ADULTS & PEDIATRICS		30.00	0 38.01
39.00 OTHER MISC REVENUE - RADIOLOGY	B	-1,284	RADIOLOGY-DIAGNOSTIC		54.00	0 39.00
40.00 OTHER MISC REVENUE - E.D.	B	-189,579	ADMINISTRATIVE & GENERAL		5.00	0 40.00
41.00 OTHER MISC REVENUE - ASC	B	-1,013,124	ASC (NON-DISTINCT PART)		75.00	0 41.00
42.00 OTHER MISC REVENUE - ENDO	B	-854	ENDOSCOPY		76.00	0 42.00
42.01 LATE PENALTY FEES - BARIATRIC SVCS	B	-50	ADULTS & PEDIATRICS		30.00	0 42.01
43.00 LATE PENALTY FEES - MAINTENANCE PLAN	B	-2,332	OPERATION OF PLANT		7.00	0 43.00
44.00 LATE PENALTY FEES - LEASED SPACE	B	-902	ADMINISTRATIVE & GENERAL		5.00	0 44.00
44.01 GAIN ON SALE/DISPOSAL PPE	B	-391,873	CAP REL COSTS-MVBLE EQUIP		2.00	9 44.01
45.00 RENTAL OF HOSPITAL SPACE	B	-780,608	CAP REL COSTS-BLDG & FIXT		1.00	14 45.00
46.00 OTHER ADJUSTMENTS (SPECIFY) (3)	B	0			0.00	0 46.00
47.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 47.00
49.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 49.00
49.01 ENTERTAINMENT - A&G	A	-4,577	ADMINISTRATIVE & GENERAL		5.00	0 49.01
49.02 ENTERTAINMENT - NURS ADMIN	A	-43	NURSING ADMINISTRATION		13.00	0 49.02
49.03 ENTERTAINMENT - PHARMACY	A	-99	PHARMACY		15.00	0 49.03
49.04 ENTERTAINMENT - OR	A	-2,622	OPERATING ROOM		50.00	0 49.04
49.05 ENTERTAINMENT - RADIOLOGY	A	-758	RADIOLOGY-DIAGNOSTIC		54.00	0 49.05
49.06 ENTERTAINMENT - RT	A	-282	RESPIRATORY THERAPY		65.00	0 49.06
49.07 ENTERTAINMENT - PT	A	-38	PHYSICAL THERAPY		66.00	0 49.07
49.08 ENTERTAINMENT - NEONATOLOGY	A	-414	NEONATAL INTENSIVE CARE UNIT		35.00	0 49.08
49.09 ADVERTISING - ASC	A	-44,723	ASC (NON-DISTINCT PART)		75.00	0 49.09
49.10 MARKETING - ROUTINE	A	-15,241	ADULTS & PEDIATRICS		30.00	0 49.10
49.11 MARKETING - L&D	A	-2,100	DELIVERY ROOM & LABOR ROOM		52.00	0 49.11
49.12 CHARITABLE EXPENSE - CASE MGMT	A	-22,149	NURSING ADMINISTRATION		13.00	0 49.12
49.13 NON CONTROLLING INTEREST INCOME LOSS	A	-15,472,555	CAP REL COSTS-BLDG & FIXT		1.00	11 49.13
49.14 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 49.14
49.15 PHYSICIAN FUNDS EXPENSE	A	-3,154,406	ADMINISTRATIVE & GENERAL		5.00	0 49.15
49.16 MILEVEL PROVIDER - ROUTINE	A	-86,796	ADULTS & PEDIATRICS		30.00	0 49.16
49.17 MILEVEL PROVIDER -L&D	A	-4,318	DELIVERY ROOM & LABOR ROOM		52.00	0 49.17
49.22 LOBBYING	A	-2,042	ADMINISTRATIVE & GENERAL		5.00	0 49.22
49.23 PROVIDER ASSESSMENT OFFSET	B	-9,032,492	ADMINISTRATIVE & GENERAL		5.00	0 49.23
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-32,014,443				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: 15-0157

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

Worksheet A-8-1

Date/Time Prepared: 11/21/2022 9:16 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	5,135,647	4,845,685	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - CAPITAL	2,001,540	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - INTEREST - CAP	52,592	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - INTEREST - A&G	317	0	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - OTHER	25,783,922	23,444,733	3.02
3.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	119,888	119,888	3.03
3.04	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACKS	652,293	652,293	3.04
3.05	13.00	NURSING ADMINISTRATION	SVH CHARGEBACKS	-5,045	-5,045	3.05
3.06	15.00	PHARMACY	SVH CHARGEBACKS	36,000	36,000	3.06
3.07	30.00	ADULTS & PEDIATRICS	SVH CHARGEBACKS	1,318	1,318	3.07
3.08	31.00	INTENSIVE CARE UNIT	SVH CHARGEBACKS	230,004	230,004	3.08
3.09	50.00	OPERATING ROOM	SVH CHARGEBACKS	279,348	279,348	3.09
3.10	52.00	DELIVERY ROOM & LABOR ROOM	SVH CHARGEBACKS	362,592	362,592	3.10
3.11	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACKS	30,215	30,215	3.11
3.12	66.00	PHYSICAL THERAPY	SVH CHARGEBACKS	41,268	41,268	3.12
3.13	91.00	EMERGENCY	SVH CHARGEBACKS	9,300	9,300	3.13
4.00	194.06	SPORTS MEDICINE & OB PHYS	SVH CHARGEBACKS	25,000	25,000	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXP - CAPITAL	709,085	717,223	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXP - A&G	3,666	0	4.02
4.03	14.00	CENTRAL SERVICES & SUPPLY	TRG ADMIN FEES - SUPPLIES	-720,894	0	4.03
4.04	13.00	NURSING ADMINISTRATION	TRG ADMIN FEES - CONTRACTED	-54,185	0	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	TRG ADMIN FEES - OTHER	-170,420	0	4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			34,523,451	30,789,822	5.00

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

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

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

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

6.00	G	ST. VINCENT HEA	100.00	ST. VINCENT HEA	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:	HOME OFFICE				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: 15-0157

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

Worksheet A-8-1

Date/Time Prepared:
11/21/2022 9:16 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	289,962	0		1.00
2.00	2,001,540	0		2.00
3.00	52,592	0		3.00
3.01	317	0		3.01
3.02	2,339,189	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
3.13	0	0		3.13
4.00	0	0		4.00
4.01	-8,138	11		4.01
4.02	3,666	0		4.02
4.03	-720,894	0		4.03
4.04	-54,185	0		4.04
4.05	-170,420	0		4.05
5.00	3,733,629			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	HOME OFFICE		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0157

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

Worksheet A-8-2

Date/Time Prepared:
11/21/2022 9:16 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	30.00	ADULTS & PEDIATRICS	338,691	338,691	0	0	0	1.00
2.00	35.00	NEONATAL INTENSIVE CARE UNIT	10,500	10,500	0	0	0	2.00
3.00	50.00	OPERATING ROOM	1,161,577	0	1,161,577	246,400	16,396	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	1,094,129	1,091,919	2,210	211,500	17	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	153,287	115,911	37,376	271,900	216	5.00
6.00	57.00	CT SCAN	44,150	44,150	0	0	0	6.00
7.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	14,423	14,423	0	0	0	7.00
8.00	91.00	EMERGENCY	139,790	0	139,790	211,500	2,882	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			2,956,547	1,615,594	1,340,953		19,511	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	1,942,295	97,115	0	0	0	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	1,729	86	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	28,236	1,412	0	0	0	5.00
6.00	57.00	CT SCAN	0	0	0	0	0	6.00
7.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	293,050	14,653	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			2,265,310	113,266	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	338,691		1.00
2.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	0	0	10,500		2.00
3.00	50.00	OPERATING ROOM	0	1,942,295	0	0		3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	0	1,729	481	1,092,400		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	28,236	9,140	125,051		5.00
6.00	57.00	CT SCAN	0	0	0	44,150		6.00
7.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	14,423		7.00
8.00	91.00	EMERGENCY	0	293,050	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	2,265,310	9,621	1,625,215		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0157

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

Worksheet B
Part I
Date/Time Prepared:
11/21/2022 9:16 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	6,732,181	6,732,181			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	4,057,956		4,057,956		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	7,419,758	88,594	0	7,508,352	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	26,486,678	427,733	206,748	292,837	5.00
7.00 00700	OPERATION OF PLANT	4,698,671	786,321	25,630	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	668,534	40,867	0	0	8.00
9.00 00900	HOUSEKEEPING	2,175,807	114,677	2,925	0	9.00
10.00 01000	DIETARY	1,189,732	147,868	3,290	0	10.00
11.00 01100	CAFETERIA	576,749	172,524	3,584	0	11.00
13.00 01300	NURSING ADMINISTRATION	2,265,297	3,102	117,052	376,537	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	-216,520	149,974	42,425	83,320	14.00
15.00 01500	PHARMACY	2,247,784	118,027	170,319	390,965	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	6,860	0	0	16.00
17.00 01700	SOCIAL SERVICE	118,336	16,279	0	11,927	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	11,280,061	1,522,900	221,628	1,649,394	30.00
31.00 03100	INTENSIVE CARE UNIT	3,275,834	156,427	142,142	439,030	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	2,418,887	155,702	35,493	341,336	35.00
43.00 04300	NURSERY	1,312,926	280,476	13,628	201,943	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	10,516,963	600,258	1,426,998	763,956	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	4,348,831	318,853	61,095	551,009	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,681,488	322,702	298,654	360,397	54.00
54.01 03480	ONCOLOGY	0	0	0	0	54.01
54.02 05402	ULTRASOUND	233,477	7,811	76,138	38,546	54.02
57.00 05700	CT SCAN	841,324	87,100	143,253	126,566	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	445,696	180,403	271,490	55,882	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	3,605,158	109,288	0	0	60.00
65.00 06500	RESPIRATORY THERAPY	1,608,435	53,840	98,935	245,148	65.00
66.00 06600	PHYSICAL THERAPY	622,817	45,780	0	102,363	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	23,069	498	0	3,118	68.00
69.00 06900	ELECTROCARDIOLOGY	177,737	5,751	13,810	26,668	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	7,476	385	7,826	838	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,731,624	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	5,272,505	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	5,587,537	0	0	0	73.00
75.00 07500	ASC (NON-DISTINCT PART)	9,554,832	287,020	393,385	597,953	75.00
76.00 03330	ENDOSCOPY	4,425,391	119,114	223,703	419,154	76.00
76.01 03020	WOUND CARE	28,304	0	0	4,596	76.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	2,860,757	308,257	56,937	325,455	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	134,282,092	6,635,391	4,057,088	7,408,938	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	458,965	37,448	0	24,900	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	481,154	0	0	74,514	192.00
194.00 07950	MISSION EFFECTIVENESS	0	0	0	0	194.00
194.01 07951	MARKETING	0	0	0	0	194.01
194.02 07952	JOINT VENTURES	0	0	0	0	194.02
194.04 07954	SCHOOL NURSE	0	20,037	0	0	194.04
194.06 07956	SPORTS MEDICINE & OB PHYS	33,571	39,305	868	0	194.06
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	135,255,782	6,732,181	4,057,956	7,508,352	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0157

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

Worksheet B
Part I
Date/Time Prepared:
11/21/2022 9:16 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
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,413,996				5.00
7.00	00700	OPERATION OF PLANT	1,400,833	6,911,455			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	180,334	52,021	941,756		8.00
9.00	00900	HOUSEKEEPING	582,998	145,976	0	3,022,383	9.00
10.00	01000	DIETARY	340,862	188,227	0	84,739	1,954,718
11.00	01100	CAFETERIA	191,381	219,613	0	98,869	0
13.00	01300	NURSING ADMINISTRATION	702,114	3,948	0	1,778	0
14.00	01400	CENTRAL SERVICES & SUPPLY	15,049	190,907	24,066	85,946	0
15.00	01500	PHARMACY	744,085	150,242	0	67,638	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,744	8,733	0	3,931	0
17.00	01700	SOCIAL SERVICE	37,252	20,722	0	9,329	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,730,181	1,938,557	291,611	872,734	1,676,036
31.00	03100	INTENSIVE CARE UNIT	1,020,239	199,121	30,604	89,644	166,734
35.00	02060	NEONATAL INTENSIVE CARE UNIT	750,268	198,199	0	89,229	0
43.00	04300	NURSERY	459,852	357,029	78,095	160,734	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,383,018	764,090	191,558	343,992	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,342,154	405,880	26,550	182,726	111,948
54.00	05400	RADIOLOGY-DIAGNOSTIC	931,218	410,779	60,795	184,932	0
54.01	03480	ONCOLOGY	0	0	0	0	0
54.02	05402	ULTRASOUND	90,490	9,943	3,771	4,476	0
57.00	05700	CT SCAN	304,601	110,873	14,332	49,915	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	242,378	229,642	20,361	103,384	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	944,234	139,117	0	62,630	0
65.00	06500	RESPIRATORY THERAPY	510,028	68,535	492	30,854	0
66.00	06600	PHYSICAL THERAPY	195,983	58,275	1,204	26,235	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	6,783	634	45	285	0
69.00	06900	ELECTROCARDIOLOGY	56,934	7,320	55	3,296	0
70.00	07000	ELECTROENCEPHALOGRAPHY	4,201	490	2	221	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,202,807	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,340,302	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,420,385	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	2,753,862	365,358	38,270	164,483	0
76.00	03330	ENDOSCOPY	1,318,659	151,625	55,479	68,261	0
76.01	03020	WOUND CARE	8,363	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	902,789	392,392	100,166	176,654	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,116,381	6,788,248	937,456	2,966,915	1,954,718
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	132,521	47,669	0	21,461	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	141,254	0	0	0	0
194.00	07950	MISSIO EFFECTIVENESS	0	0	0	0	0
194.01	07951	MARKETING	0	0	0	0	0
194.02	07952	JOINT VENTURES	0	0	0	0	0
194.04	07954	SCHOOL NURSE	5,094	25,506	0	11,483	0
194.06	07956	SPORTS MEDICINE & OB PHYS	18,746	50,032	4,300	22,524	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	27,413,996	6,911,455	941,756	3,022,383	1,954,718

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet B Part I Date/Time Prepared: 11/21/2022 9:16 am
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		11.00	13.00	14.00	15.00	16.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
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	1,262,720					11.00	
13.00	01300	59,824	3,529,652				13.00	
14.00	01400	28,108	9,630	412,905			14.00	
15.00	01500	61,982	0	1,695	3,952,737		15.00	
16.00	01600	0	0	0	0	21,268	16.00	
17.00	01700	3,228	0	0	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	298,584	1,337,904	10,485	0	1,592	30.00	
31.00	03100	55,579	293,575	4,277	0	441	31.00	
35.00	02060	47,895	289,328	2,033	0	514	35.00	
43.00	04300	35,854	209,199	1,704	0	214	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	130,294	521,301	77,122	0	4,351	50.00	
52.00	05200	87,055	382,316	5,560	0	1,135	52.00	
54.00	05400	66,813	94,372	9,503	0	4,614	54.00	
54.01	03480	0	0	0	0	0	54.01	
54.02	05402	15,763	0	45	0	1,135	54.02	
57.00	05700	21,210	2,212	1,861	0	250	57.00	
58.00	05800	10,115	733	1,026	0	83	58.00	
59.00	05900	0	0	0	0	0	59.00	
60.00	06000	0	0	60	0	1,149	60.00	
65.00	06500	30,601	0	2,485	0	245	65.00	
66.00	06600	19,213	0	232	0	80	66.00	
67.00	06700	0	0	0	0	0	67.00	
68.00	06800	652	0	0	0	4	68.00	
69.00	06900	400	0	441	0	37	69.00	
70.00	07000	184	0	39	0	32	70.00	
71.00	07100	0	0	96,420	0	0	71.00	
72.00	07200	0	0	110,031	0	0	72.00	
73.00	07300	0	0	0	3,952,737	0	73.00	
75.00	07500	131,269	0	64,456	0	2,506	75.00	
76.00	03330	87,922	145,054	17,561	0	1,657	76.00	
76.01	03020	824	0	0	0	6	76.01	
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	50,309	244,028	5,369	0	1,223	91.00	
92.00	09200						92.00	
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		1,243,678	3,529,652	412,405	3,952,737	21,268	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	8,035	0	467	0	0	190.00	
192.00	19200	11,007	0	33	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	
194.04	07954	0	0	0	0	0	194.04	
194.06	07956	0	0	0	0	0	194.06	
200.00	Cross Foot Adjustments						200.00	
201.00	Negative Cost Centers						201.00	
202.00	TOTAL (sum lines 118 through 201)		1,262,720	3,529,652	412,905	3,952,737	21,268	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0157		Period: From 07/01/2021 To 06/30/2022		Worksheet B Part I Date/Time Prepared: 11/21/2022 9:16 am	
Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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
17.00	01700	SOCIAL SERVICE	217,073					17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	48,723	24,880,390	0	24,880,390		30.00
31.00	03100	INTENSIVE CARE UNIT	22,276	5,895,923	0	5,895,923		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	36,163	4,365,047	0	4,365,047		35.00
43.00	04300	NURSERY	0	3,111,654	0	3,111,654		43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,265	18,728,166	0	18,728,166		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,462	7,852,574	0	7,852,574		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,426,267	0	5,426,267		54.00
54.01	03480	ONCOLOGY	0	0	0	0		54.01
54.02	05402	ULTRASOUND	0	481,595	0	481,595		54.02
57.00	05700	CT SCAN	0	1,703,497	0	1,703,497		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,561,193	0	1,561,193		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	4,861,636	0	4,861,636		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,649,598	0	2,649,598		65.00
66.00	06600	PHYSICAL THERAPY	0	1,072,182	0	1,072,182		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	35,088	0	35,088		68.00
69.00	06900	ELECTROCARDIOLOGY	0	292,449	0	292,449		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	21,694	0	21,694		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,030,851	0	6,030,851		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,722,838	0	6,722,838		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,960,659	0	10,960,659		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	14,353,394	0	14,353,394		75.00
76.00	03330	ENDOSCOPY	11,372	7,044,952	0	7,044,952		76.00
76.01	03020	WOUND CARE	0	42,093	0	42,093		76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	55,424	5,479,760	0	5,479,760		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	205,685	133,573,500	0	133,573,500		118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	731,466	0	731,466		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,388	719,350	0	719,350		192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0		194.00
194.01	07951	MARKETING	0	0	0	0		194.01
194.02	07952	JOINT VENTURES	0	0	0	0		194.02
194.04	07954	SCHOOL NURSE	0	62,120	0	62,120		194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	169,346	0	169,346		194.06
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	217,073	135,255,782	0	135,255,782		202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet B Part II Date/Time Prepared: 11/21/2022 9:16 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	88,594	0	88,594	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,001,540	427,733	206,748	2,636,021	5.00
7.00 00700	OPERATION OF PLANT	0	786,321	25,630	811,951	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	40,867	0	40,867	8.00
9.00 00900	HOUSEKEEPING	0	114,677	2,925	117,602	9.00
10.00 01000	DIETARY	0	147,868	3,290	151,158	10.00
11.00 01100	CAFETERIA	0	172,524	3,584	176,108	11.00
13.00 01300	NURSING ADMINISTRATION	0	3,102	117,052	120,154	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	149,974	42,425	192,399	14.00
15.00 01500	PHARMACY	0	118,027	170,319	288,346	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	6,860	0	6,860	16.00
17.00 01700	SOCIAL SERVICE	0	16,279	0	16,279	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,522,900	221,628	1,744,528	30.00
31.00 03100	INTENSIVE CARE UNIT	0	156,427	142,142	298,569	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	155,702	35,493	191,195	35.00
43.00 04300	NURSERY	0	280,476	13,628	294,104	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	600,258	1,426,998	2,027,256	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	318,853	61,095	379,948	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	322,702	298,654	621,356	54.00
54.01 03480	ONCOLOGY	0	0	0	0	54.01
54.02 05402	ULTRASOUND	0	7,811	76,138	83,949	54.02
57.00 05700	CT SCAN	0	87,100	143,253	230,353	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	180,403	271,490	451,893	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	0	109,288	0	109,288	60.00
65.00 06500	RESPIRATORY THERAPY	0	53,840	98,935	152,775	65.00
66.00 06600	PHYSICAL THERAPY	0	45,780	0	45,780	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	498	0	498	68.00
69.00 06900	ELECTROCARDIOLOGY	0	5,751	13,810	19,561	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	385	7,826	8,211	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
75.00 07500	ASC (NON-DISTINCT PART)	0	287,020	393,385	680,405	75.00
76.00 03330	ENDOSCOPY	0	119,114	223,703	342,817	76.00
76.01 03020	WOUND CARE	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	308,257	56,937	365,194	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	2,001,540	6,635,391	4,057,088	12,694,019	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	37,448	0	37,448	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	MISSION EFFECTIVENESS	0	0	0	0	194.00
194.01 07951	MARKETING	0	0	0	0	194.01
194.02 07952	JOINT VENTURES	0	0	0	0	194.02
194.04 07954	SCHOOL NURSE	0	20,037	0	20,037	194.04
194.06 07956	SPORTS MEDICINE & OB PHYS	0	39,305	868	40,173	194.06
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2,001,540	6,732,181	4,057,956	12,791,677	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0157		Period: From 07/01/2021 To 06/30/2022		Worksheet B Part II Date/Time Prepared: 11/21/2022 9:16 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
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,639,477					5.00
7.00	00700	OPERATION OF PLANT	134,872	946,823				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,363	7,127	65,357			8.00
9.00	00900	HOUSEKEEPING	56,131	19,998	0	193,731		9.00
10.00	01000	DIETARY	32,818	25,786	0	5,432	215,194	10.00
11.00	01100	CAFETERIA	18,426	30,085	0	6,337	0	11.00
13.00	01300	NURSING ADMINISTRATION	67,600	541	0	114	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,449	26,153	1,670	5,509	0	14.00
15.00	01500	PHARMACY	71,641	20,582	0	4,336	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	168	1,196	0	252	0	16.00
17.00	01700	SOCIAL SERVICE	3,587	2,839	0	598	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	359,194	265,569	20,237	55,941	184,514	30.00
31.00	03100	INTENSIVE CARE UNIT	98,229	27,278	2,124	5,746	18,356	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	72,236	27,152	0	5,719	0	35.00
43.00	04300	NURSERY	44,275	48,911	5,420	10,303	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	325,718	104,675	13,294	22,049	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	129,223	55,603	1,843	11,713	12,324	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	89,658	56,274	4,219	11,854	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	8,712	1,362	262	287	0	54.02
57.00	05700	CT SCAN	29,327	15,189	995	3,199	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	23,336	31,459	1,413	6,627	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	90,911	19,058	0	4,015	0	60.00
65.00	06500	RESPIRATORY THERAPY	49,106	9,389	34	1,978	0	65.00
66.00	06600	PHYSICAL THERAPY	18,869	7,983	84	1,682	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	653	87	3	18	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,482	1,003	4	211	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	404	67	0	14	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	115,806	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	129,045	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	136,755	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	265,142	50,052	2,656	10,543	0	75.00
76.00	03330	ENDOSCOPY	126,961	20,772	3,850	4,375	0	76.00
76.01	03020	WOUND CARE	805	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	86,921	53,755	6,951	11,323	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,610,823	929,945	65,059	190,175	215,194	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,759	6,530	0	1,376	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,600	0	0	0	0	192.00
194.00	07950	MISSISSIPPI EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	490	3,494	0	736	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	1,805	6,854	298	1,444	0	194.06
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)	2,639,477	946,823	65,357	193,731	215,194	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0157		Period: From 07/01/2021 To 06/30/2022		Worksheet B Part II Date/Time Prepared: 11/21/2022 9:16 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
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	230,956					11.00
13.00	01300	NURSING ADMINISTRATION	10,942	203,794				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,141	556	153,413			14.00
15.00	01500	PHARMACY	11,337	0	630	401,486		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	8,476	16.00
17.00	01700	SOCIAL SERVICE	590	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	54,613	77,247	3,896	0	597	30.00
31.00	03100	INTENSIVE CARE UNIT	10,166	16,950	1,589	0	165	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	8,760	16,705	755	0	193	35.00
43.00	04300	NURSERY	6,558	12,079	633	0	80	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	23,831	30,099	28,656	0	2,132	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,923	22,074	2,066	0	426	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,220	5,449	3,531	0	1,730	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	2,883	0	17	0	426	54.02
57.00	05700	CT SCAN	3,879	128	692	0	94	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,850	42	381	0	31	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	22	0	431	60.00
65.00	06500	RESPIRATORY THERAPY	5,597	0	923	0	92	65.00
66.00	06600	PHYSICAL THERAPY	3,514	0	86	0	30	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	119	0	0	0	2	68.00
69.00	06900	ELECTROCARDIOLOGY	73	0	164	0	14	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	34	0	15	0	12	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	35,827	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	40,874	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	401,486	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	24,009	0	23,950	0	940	75.00
76.00	03330	ENDOSCOPY	16,081	8,375	6,525	0	621	76.00
76.01	03020	WOUND CARE	151	0	0	0	2	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	9,202	14,090	1,995	0	458	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	227,473	203,794	153,227	401,486	8,476	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,470	0	174	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,013	0	12	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	0	0	0	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	80,447	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	230,956	203,794	233,860	401,486	8,476	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0157		Period: From 07/01/2021 To 06/30/2022		Worksheet B Part II Date/Time Prepared: 11/21/2022 9:16 am	
Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	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
17.00	01700	SOCIAL SERVICE	24,034				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,395	2,791,185	0	2,791,185	30.00
31.00	03100	INTENSIVE CARE UNIT	2,466	486,819	0	486,819	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	4,004	330,747	0	330,747	35.00
43.00	04300	NURSERY	0	424,746	0	424,746	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	472	2,587,197	0	2,587,197	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,041	640,686	0	640,686	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	810,544	0	810,544	54.00
54.01	03480	ONCOLOGY	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0	98,353	0	98,353	54.02
57.00	05700	CT SCAN	0	285,350	0	285,350	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	517,691	0	517,691	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	223,725	0	223,725	60.00
65.00	06500	RESPIRATORY THERAPY	0	222,787	0	222,787	65.00
66.00	06600	PHYSICAL THERAPY	0	79,236	0	79,236	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,417	0	1,417	68.00
69.00	06900	ELECTROCARDIOLOGY	0	26,827	0	26,827	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	8,767	0	8,767	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	151,633	0	151,633	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	169,919	0	169,919	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	538,241	0	538,241	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	1,064,753	0	1,064,753	75.00
76.00	03330	ENDOSCOPY	1,259	536,582	0	536,582	76.00
76.01	03020	WOUND CARE	0	1,012	0	1,012	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	6,136	559,866	0	559,866	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,773	12,558,083	0	12,558,083	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	60,051	0	60,051	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,261	17,765	0	17,765	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	0	24,757	0	24,757	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	50,574	0	50,574	194.06
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	80,447	0	80,447	201.00
202.00		TOTAL (sum lines 118 through 201)	24,034	12,791,677	0	12,791,677	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0157

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

Worksheet B-1
Date/Time Prepared:
11/21/2022 9:16 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	297,345				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		4,449,829			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,913	0	41,403,581		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	18,892	226,713	1,614,805	-27,413,996	107,841,786
7.00 00700	OPERATION OF PLANT	34,730	28,105	0	0	5,510,622
8.00 00800	LAUNDRY & LINEN SERVICE	1,805	0	0	0	709,401
9.00 00900	HOUSEKEEPING	5,065	3,207	0	0	2,293,409
10.00 01000	DIETARY	6,531	3,608	0	0	1,340,890
11.00 01100	CAFETERIA	7,620	3,930	0	0	752,857
13.00 01300	NURSING ADMINISTRATION	137	128,356	2,076,357	0	2,761,988
14.00 01400	CENTRAL SERVICES & SUPPLY	6,624	46,522	459,454	0	59,199
15.00 01500	PHARMACY	5,213	186,767	2,155,916	0	2,927,095
16.00 01600	MEDICAL RECORDS & LIBRARY	303	0	0	0	6,860
17.00 01700	SOCIAL SERVICE	719	0	65,772	0	146,542
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	67,263	243,030	9,095,228	0	14,673,983
31.00 03100	INTENSIVE CARE UNIT	6,909	155,869	2,420,967	0	4,013,433
35.00 02060	NEONATAL INTENSIVE CARE UNIT	6,877	38,921	1,882,244	0	2,951,418
43.00 04300	NURSERY	12,388	14,944	1,113,586	0	1,808,973
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	26,512	1,564,799	4,212,720	0	13,308,175
52.00 05200	DELIVERY ROOM & LABOR ROOM	14,083	66,995	3,038,459	0	5,279,788
54.00 05400	RADIOLOGY-DIAGNOSTIC	14,253	327,495	1,987,358	0	3,663,241
54.01 03480	ONCOLOGY	0	0	0	0	0
54.02 05402	ULTRASOUND	345	83,491	212,554	0	355,972
57.00 05700	CT SCAN	3,847	157,087	697,929	0	1,198,243
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	7,968	297,708	308,154	0	953,471
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	4,827	0	0	0	3,714,446
65.00 06500	RESPIRATORY THERAPY	2,378	108,489	1,351,831	0	2,006,358
66.00 06600	PHYSICAL THERAPY	2,022	0	564,466	0	770,960
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	22	0	17,196	0	26,685
69.00 06900	ELECTROCARDIOLOGY	254	15,144	147,056	0	223,966
70.00 07000	ELECTROENCEPHALOGRAPHY	17	8,582	4,621	0	16,525
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,731,624
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,272,505
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	5,587,537
75.00 07500	ASC (NON-DISTINCT PART)	12,677	431,374	3,297,322	0	10,833,190
76.00 03330	ENDOSCOPY	5,261	245,306	2,311,364	0	5,187,362
76.01 03020	WOUND CARE	0	0	25,343	0	32,900
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	13,615	62,435	1,794,673	0	3,551,406
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	293,070	4,448,877	40,855,375	-27,413,996	106,671,024
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,654	0	137,309	0	521,313
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	410,897	0	555,668
194.00 07950	MISSION EFFECTIVENESS	0	0	0	0	0
194.01 07951	MARKETING	0	0	0	0	0
194.02 07952	JOINT VENTURES	0	0	0	0	0
194.04 07954	SCHOOL NURSE	885	0	0	0	20,037
194.06 07956	SPORTS MEDICINE & OB PHYS	1,736	952	0	0	73,744
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	6,732,181	4,057,956	7,508,352		27,413,996
203.00	Unit cost multiplier (Wkst. B, Part I)	22.640976	0.911935	0.181345		0.254206
204.00	Cost to be allocated (per Wkst. B, Part II)			88,594		2,639,477
205.00	Unit cost multiplier (Wkst. B, Part II)			0.002140		0.024475
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0157

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

Worksheet B-1

Date/Time Prepared:
11/21/2022 9:16 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	239,810				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	1,805	567,935			8.00	
9.00	00900	HOUSEKEEPING	5,065	0	232,940		9.00	
10.00	01000	DIETARY	6,531	0	6,531	53,483	10.00	
11.00	01100	CAFETERIA	7,620	0	7,620	0	876,949	11.00
13.00	01300	NURSING ADMINISTRATION	137	0	137	0	41,547	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,624	14,513	6,624	0	19,521	14.00
15.00	01500	PHARMACY	5,213	0	5,213	0	43,046	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	303	0	303	0	0	16.00
17.00	01700	SOCIAL SERVICE	719	0	719	0	2,242	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	67,263	175,860	67,263	45,858	207,366	30.00
31.00	03100	INTENSIVE CARE UNIT	6,909	18,456	6,909	4,562	38,599	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	6,877	0	6,877	0	33,263	35.00
43.00	04300	NURSERY	12,388	47,096	12,388	0	24,900	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,512	115,521	26,512	0	90,488	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,083	16,011	14,083	3,063	60,459	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,253	36,663	14,253	0	46,401	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	345	2,274	345	0	10,947	54.02
57.00	05700	CT SCAN	3,847	8,643	3,847	0	14,730	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,968	12,279	7,968	0	7,025	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,827	0	4,827	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,378	297	2,378	0	21,252	65.00
66.00	06600	PHYSICAL THERAPY	2,022	726	2,022	0	13,343	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	22	27	22	0	453	68.00
69.00	06900	ELECTROCARDIOLOGY	254	33	254	0	278	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17	1	17	0	128	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
75.00	07500	ASC (NON-DISTINCT PART)	12,677	23,079	12,677	0	91,165	75.00
76.00	03330	ENDOSCOPY	5,261	33,457	5,261	0	61,061	76.00
76.01	03020	WOUND CARE	0	0	0	0	572	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	13,615	60,406	13,615	0	34,939	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	235,535	565,342	228,665	53,483	863,725	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,654	0	1,654	0	5,580	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	7,644	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	885	0	885	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	1,736	2,593	1,736	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,911,455	941,756	3,022,383	1,954,718	1,262,720	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.820545	1.658211	12.974942	36.548399	1.439901	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	946,823	65,357	193,731	215,194	230,956	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.948222	0.115078	0.831678	4.023596	0.263363	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: 15-0157

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

Worksheet B-1
Date/Time Prepared:
11/21/2022 9:16 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (PATIENT REVENUE)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
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	298,351					13.00
14.00	01400	814	19,786,235				14.00
15.00	01500	0	81,229	5,587,537			15.00
16.00	01600	0	0	0	897,142,781		16.00
17.00	01700	0	0	0	0	13,896	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	113,089	502,425	0	66,321,966	3,119	30.00
31.00	03100	24,815	204,971	0	18,381,368	1,426	31.00
35.00	02060	24,456	97,408	0	21,400,641	2,315	35.00
43.00	04300	17,683	81,668	0	8,902,754	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	44,064	3,695,684	0	192,254,578	273	50.00
52.00	05200	32,316	266,419	0	47,310,827	1,758	52.00
54.00	05400	7,977	455,391	0	192,254,578	0	54.00
54.01	03480	0	0	0	0	0	54.01
54.02	05402	0	2,150	0	47,310,827	0	54.02
57.00	05700	187	89,187	0	10,417,020	0	57.00
58.00	05800	62	49,163	0	3,446,123	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	2,889	0	47,893,054	0	60.00
65.00	06500	0	119,062	0	10,226,041	0	65.00
66.00	06600	0	11,100	0	3,345,831	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	184,265	0	68.00
69.00	06900	0	21,120	0	1,521,886	0	69.00
70.00	07000	0	1,881	0	1,324,494	0	70.00
71.00	07100	0	4,620,462	0	0	0	71.00
72.00	07200	0	5,272,505	0	0	0	72.00
73.00	07300	0	0	5,587,537	0	0	73.00
75.00	07500	0	3,088,732	0	104,424,270	0	75.00
76.00	03330	12,261	841,531	0	69,044,366	728	76.00
76.01	03020	0	0	0	237,674	0	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	20,627	257,289	0	50,940,218	3,548	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		298,351	19,762,266	5,587,537	897,142,781	13,167	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	22,399	0	0	0	190.00
192.00	19200	0	1,570	0	0	729	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
194.04	07954	0	0	0	0	0	194.04
194.06	07956	0	0	0	0	0	194.06
200.00							200.00
201.00							201.00
202.00		3,529,652	412,905	3,952,737	21,268	217,073	202.00
203.00		11.830535	0.020868	0.707420	0.000024	15.621258	203.00
204.00		203,794	233,860	401,486	8,476	24,034	204.00
205.00		0.683068	0.007754	0.071854	0.000009	1.729562	205.00
206.00							206.00
207.00							207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Prepared: 11/21/2022 9:16 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		24,880,390	0	24,880,390	30.00
31.00	03100 INTENSIVE CARE UNIT		5,895,923	0	5,895,923	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT		4,365,047	0	4,365,047	35.00
43.00	04300 NURSERY		3,111,654	0	3,111,654	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		18,728,166	0	18,728,166	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		7,852,574	481	7,853,055	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		5,426,267	9,140	5,435,407	54.00
54.01	03480 ONCOLOGY		0	0	0	54.01
54.02	05402 ULTRASOUND		481,595	0	481,595	54.02
57.00	05700 CT SCAN		1,703,497	0	1,703,497	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		1,561,193	0	1,561,193	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		4,861,636	0	4,861,636	60.00
65.00	06500 RESPIRATORY THERAPY	0	2,649,598	0	2,649,598	65.00
66.00	06600 PHYSICAL THERAPY	0	1,072,182	0	1,072,182	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	35,088	0	35,088	68.00
69.00	06900 ELECTROCARDIOLOGY		292,449	0	292,449	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		21,694	0	21,694	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		6,030,851	0	6,030,851	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		6,722,838	0	6,722,838	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		10,960,659	0	10,960,659	73.00
75.00	07500 ASC (NON-DISTINCT PART)		14,353,394	0	14,353,394	75.00
76.00	03330 ENDOSCOPY		7,044,952	0	7,044,952	76.00
76.01	03020 WOUND CARE		42,093	0	42,093	76.01
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY		5,479,760	0	5,479,760	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		3,674,561	0	3,674,561	92.00
200.00	Subtotal (see instructions)	0	137,248,061	9,621	137,257,682	200.00
201.00	Less Observation Beds		3,674,561		3,674,561	201.00
202.00	Total (see instructions)	0	133,573,500	9,621	133,583,121	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Prepared: 11/21/2022 9:16 am
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Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00				
Title XVIII Hospital PPS								
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	54,843,730		54,843,730			30.00
31.00	03100	INTENSIVE CARE UNIT	18,381,368		18,381,368			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	21,400,641		21,400,641			35.00
43.00	04300	NURSERY	8,902,754		8,902,754			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	59,145,281	133,109,297	192,254,578	0.097413	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	46,290,857	1,019,970	47,310,827	0.165978	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,462,193	25,883,230	28,345,423	0.191434	0.000000	54.00
54.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	54.01
54.02	05402	ULTRASOUND	653,000	2,372,238	3,025,238	0.159192	0.000000	54.02
57.00	05700	CT SCAN	1,938,859	8,478,161	10,417,020	0.163530	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	193,099	3,253,024	3,446,123	0.453029	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	25,594,460	22,298,594	47,893,054	0.101510	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	6,970,102	3,255,939	10,226,041	0.259103	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,667,891	1,677,940	3,345,831	0.320453	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	126,234	58,031	184,265	0.190421	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,323,983	197,903	1,521,886	0.192162	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	445,197	879,297	1,324,494	0.016379	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,406,732	29,512,850	47,919,582	0.125854	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,397,211	9,271,951	17,669,162	0.380484	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,811,119	14,198,172	38,009,291	0.288368	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	104,424,270	104,424,270	0.137453	0.000000	75.00
76.00	03330	ENDOSCOPY	2,258,760	66,785,606	69,044,366	0.102035	0.000000	76.00
76.01	03020	WOUND CARE	227,353	10,321	237,674	0.177104	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	9,925,128	41,015,090	50,940,218	0.107572	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,810,417	8,667,819	11,478,236	0.320133	0.000000	92.00
200.00		Subtotal (see instructions)	316,176,369	476,369,703	792,546,072			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	316,176,369	476,369,703	792,546,072			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Prepared: 11/21/2022 9:16 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
31.00	03100 INTENSIVE CARE UNIT		31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT		35.00
43.00	04300 NURSERY		43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.097413	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.165989	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.191756	54.00
54.01	03480 ONCOLOGY	0.000000	54.01
54.02	05402 ULTRASOUND	0.159192	54.02
57.00	05700 CT SCAN	0.163530	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.453029	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000 LABORATORY	0.101510	60.00
65.00	06500 RESPIRATORY THERAPY	0.259103	65.00
66.00	06600 PHYSICAL THERAPY	0.320453	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0.190421	68.00
69.00	06900 ELECTROCARDIOLOGY	0.192162	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.016379	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.125854	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.380484	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.288368	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.137453	75.00
76.00	03330 ENDOSCOPY	0.102035	76.00
76.01	03020 WOUND CARE	0.177104	76.01
OUTPATIENT SERVICE COST CENTERS			
91.00	09100 EMERGENCY	0.107572	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.320133	92.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Prepared: 11/21/2022 9:16 am
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		Title XIX		Hospital		Cost		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
				Total Costs	RCE Disallowance			
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	24,880,390		24,880,390	0	24,880,390	30.00
31.00	03100	INTENSIVE CARE UNIT	5,895,923		5,895,923	0	5,895,923	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	4,365,047		4,365,047	0	4,365,047	35.00
43.00	04300	NURSERY	3,111,654		3,111,654	0	3,111,654	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	18,728,166		18,728,166	0	18,728,166	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,852,574		7,852,574	481	7,853,055	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,426,267		5,426,267	9,140	5,435,407	54.00
54.01	03480	ONCOLOGY	0		0	0	0	54.01
54.02	05402	ULTRASOUND	481,595		481,595	0	481,595	54.02
57.00	05700	CT SCAN	1,703,497		1,703,497	0	1,703,497	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,561,193		1,561,193	0	1,561,193	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	4,861,636		4,861,636	0	4,861,636	60.00
65.00	06500	RESPIRATORY THERAPY	2,649,598	0	2,649,598	0	2,649,598	65.00
66.00	06600	PHYSICAL THERAPY	1,072,182	0	1,072,182	0	1,072,182	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	35,088	0	35,088	0	35,088	68.00
69.00	06900	ELECTROCARDIOLOGY	292,449		292,449	0	292,449	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	21,694		21,694	0	21,694	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,030,851		6,030,851	0	6,030,851	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,722,838		6,722,838	0	6,722,838	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,960,659		10,960,659	0	10,960,659	73.00
75.00	07500	ASC (NON-DISTINCT PART)	14,353,394		14,353,394	0	14,353,394	75.00
76.00	03330	ENDOSCOPY	7,044,952		7,044,952	0	7,044,952	76.00
76.01	03020	WOUND CARE	42,093		42,093	0	42,093	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	5,479,760		5,479,760	0	5,479,760	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,674,561		3,674,561		3,674,561	92.00
200.00		Subtotal (see instructions)	137,248,061	0	137,248,061	9,621	137,257,682	200.00
201.00		Less Observation Beds	3,674,561		3,674,561		3,674,561	201.00
202.00		Total (see instructions)	133,573,500	0	133,573,500	9,621	133,583,121	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0157		Period: From 07/01/2021 To 06/30/2022		Worksheet C Part I Date/Time Prepared: 11/21/2022 9:16 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	54,843,730		54,843,730				30.00
31.00	03100	INTENSIVE CARE UNIT	18,381,368		18,381,368				31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	21,400,641		21,400,641				35.00
43.00	04300	NURSERY	8,902,754		8,902,754				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	59,145,281	133,109,297	192,254,578	0.097413	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	46,290,857	1,019,970	47,310,827	0.165978	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,462,193	25,883,230	28,345,423	0.191434	0.000000		54.00
54.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000		54.01
54.02	05402	ULTRASOUND	653,000	2,372,238	3,025,238	0.159192	0.000000		54.02
57.00	05700	CT SCAN	1,938,859	8,478,161	10,417,020	0.163530	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	193,099	3,253,024	3,446,123	0.453029	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000		59.00
60.00	06000	LABORATORY	25,594,460	22,298,594	47,893,054	0.101510	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	6,970,102	3,255,939	10,226,041	0.259103	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	1,667,891	1,677,940	3,345,831	0.320453	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	126,234	58,031	184,265	0.190421	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	1,323,983	197,903	1,521,886	0.192162	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	445,197	879,297	1,324,494	0.016379	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,406,732	29,512,850	47,919,582	0.125854	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,397,211	9,271,951	17,669,162	0.380484	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,811,119	14,198,172	38,009,291	0.288368	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	104,424,270	104,424,270	0.137453	0.000000		75.00
76.00	03330	ENDOSCOPY	2,258,760	66,785,606	69,044,366	0.102035	0.000000		76.00
76.01	03020	WOUND CARE	227,353	10,321	237,674	0.177104	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	9,925,128	41,015,090	50,940,218	0.107572	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,810,417	8,667,819	11,478,236	0.320133	0.000000		92.00
200.00		Subtotal (see instructions)	316,176,369	476,369,703	792,546,072				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	316,176,369	476,369,703	792,546,072				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Prepared: 11/21/2022 9:16 am
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		35.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	03480	ONCOLOGY	0.000000	54.01
54.02	05402	ULTRASOUND	0.000000	54.02
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
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
76.00	03330	ENDOSCOPY	0.000000	76.00
76.01	03020	WOUND CARE	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part I Date/Time Prepared: 11/21/2022 9:16 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,791,185	0	2,791,185	17,442	160.03	30.00
31.00	INTENSIVE CARE UNIT	486,819		486,819	2,281	213.42	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	330,747		330,747	2,339	141.41	35.00
43.00	NURSERY	424,746		424,746	3,046	139.44	43.00
200.00	Total (lines 30 through 199)	4,033,497		4,033,497	25,108		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,444	551,143				
31.00	INTENSIVE CARE UNIT	1,221	260,586				
35.00	NEONATAL INTENSIVE CARE UNIT	0	0				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	4,665	811,729				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part II Date/Time Prepared: 11/21/2022 9:16 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Title XVIII		Capital Costs (column 3 x column 4)	
					Hospital	Inpatient Program Charges		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,587,197	192,254,578	0.013457	16,457,105	221,463	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	640,686	47,310,827	0.013542	3,183	43	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	810,544	28,345,423	0.028595	1,126,756	32,220	54.00
54.01	03480	ONCOLOGY	0	0	0.000000	0	0	54.01
54.02	05402	ULTRASOUND	98,353	3,025,238	0.032511	214,950	6,988	54.02
57.00	05700	CT SCAN	285,350	10,417,020	0.027393	825,920	22,624	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	517,691	3,446,123	0.150224	67,376	10,121	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	223,725	47,893,054	0.004671	6,930,620	32,373	60.00
65.00	06500	RESPIRATORY THERAPY	222,787	10,226,041	0.021786	1,977,497	43,082	65.00
66.00	06600	PHYSICAL THERAPY	79,236	3,345,831	0.023682	684,297	16,206	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,417	184,265	0.007690	62,841	483	68.00
69.00	06900	ELECTROCARDIOLOGY	26,827	1,521,886	0.017627	485,071	8,550	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,767	1,324,494	0.006619	277,837	1,839	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	151,633	47,919,582	0.003164	3,026,020	9,574	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	169,919	17,669,162	0.009617	5,442,193	52,338	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	538,241	38,009,291	0.014161	5,427,501	76,859	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,064,753	104,424,270	0.010196	0	0	75.00
76.00	03330	ENDOSCOPY	536,582	69,044,366	0.007772	620,533	4,823	76.00
76.01	03020	WOUND CARE	1,012	237,674	0.004258	88,968	379	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	559,866	50,940,218	0.010991	3,811,224	41,889	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	412,227	11,478,236	0.035914	827,196	29,708	92.00
200.00		Total (lines 50 through 199)	8,936,813	689,017,579		48,357,088	611,562	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part III Date/Time Prepared: 11/21/2022 9:16 am
Title XVIII			Hospital	PPS

Cost Center Description		Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
		1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	35.00
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 col. 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	17,442	0.00	3,444	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,281	0.00	1,221	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	2,339	0.00	0	35.00
43.00	04300	NURSERY		0	3,046	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	25,108		4,665	200.00

Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
		9.00	

INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	35.00
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: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Prepared: 11/21/2022 9:16 am
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Cost Center Description	Title XVIII						Hospital	
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	PPS		
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0	0	0	0	0	54.02
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03330	ENDOSCOPY	0	0	0	0	0	76.00
76.01	03020	WOUND CARE	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Prepared: 11/21/2022 9:16 am
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	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	192,254,578	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	47,310,827	0.000000	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	28,345,423	0.000000	54.00
54.01 03480 ONCOLOGY	0	0	0	0	0.000000	54.01
54.02 05402 ULTRASOUND	0	0	0	3,025,238	0.000000	54.02
57.00 05700 CT SCAN	0	0	0	10,417,020	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,446,123	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	47,893,054	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	10,226,041	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	3,345,831	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	184,265	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	1,521,886	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	1,324,494	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	47,919,582	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,669,162	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	38,009,291	0.000000	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	104,424,270	0.000000	75.00
76.00 03330 ENDOSCOPY	0	0	0	69,044,366	0.000000	76.00
76.01 03020 WOUND CARE	0	0	0	237,674	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	0	0	50,940,218	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	11,478,236	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	0	689,017,579		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Prepared: 11/21/2022 9:16 am
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Cost Center Description		Title XVIII				Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0.000000	16,457,105	0	18,487,998	0	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	3,183	0	13,597	0	52.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	1,126,756	0	1,517,042	0	54.00	
54.01	03480 ONCOLOGY	0.000000	0	0	0	0	54.01	
54.02	05402 ULTRASOUND	0.000000	214,950	0	584,573	0	54.02	
57.00	05700 CT SCAN	0.000000	825,920	0	2,191,138	0	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	67,376	0	619,924	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00	06000 LABORATORY	0.000000	6,930,620	0	4,423,143	0	60.00	
65.00	06500 RESPIRATORY THERAPY	0.000000	1,977,497	0	1,009,439	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	684,297	0	29,953	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	62,841	0	3,045	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0.000000	485,071	0	75,786	0	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	277,837	0	162,710	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	3,026,020	0	2,176,529	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	5,442,193	0	1,549,634	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	5,427,501	0	3,850,482	0	73.00	
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00	
76.00	03330 ENDOSCOPY	0.000000	620,533	0	3,904,515	0	76.00	
76.01	03020 WOUND CARE	0.000000	88,968	0	4,813	0	76.01	
OUTPATIENT SERVICE COST CENTERS								
91.00	09100 EMERGENCY	0.000000	3,811,224	0	8,075,368	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	827,196	0	2,151,295	0	92.00	
200.00	Total (lines 50 through 199)		48,357,088	0	50,830,984	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Prepared: 11/21/2022 9:16 am
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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	0.097413	18,487,998	0	0	1,800,971	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.165978	13,597	0	0	2,257	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.191434	1,517,042	0	0	290,413	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0.159192	584,573	0	0	93,059	54.02
57.00	05700	CT SCAN	0.163530	2,191,138	0	0	358,317	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.453029	619,924	0	0	280,844	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.101510	4,423,143	0	0	448,993	60.00
65.00	06500	RESPIRATORY THERAPY	0.259103	1,009,439	0	0	261,549	65.00
66.00	06600	PHYSICAL THERAPY	0.320453	29,953	0	0	9,599	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.190421	3,045	0	0	580	68.00
69.00	06900	ELECTROCARDIOLOGY	0.192162	75,786	0	0	14,563	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.016379	162,710	0	0	2,665	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.125854	2,176,529	0	0	273,925	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.380484	1,549,634	0	0	589,611	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.288368	3,850,482	0	3,214	1,110,356	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.137453	0	0	0	0	75.00
76.00	03330	ENDOSCOPY	0.102035	3,904,515	0	0	398,397	76.00
76.01	03020	WOUND CARE	0.177104	4,813	0	0	852	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.107572	8,075,368	0	0	868,683	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.320133	2,151,295	0	0	688,701	92.00
200.00		Subtotal (see instructions)		50,830,984	0	3,214	7,494,335	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		50,830,984	0	3,214	7,494,335	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Prepared: 11/21/2022 9:16 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03480 ONCOLOGY	0	0	54.01
54.02	05402 ULTRASOUND	0	0	54.02
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	927	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03330 ENDOSCOPY	0	0	76.00
76.01	03020 WOUND CARE	0	0	76.01
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	0	927	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	927	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Prepared: 11/21/2022 9:16 am
		Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
						1.00	2.00	3.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.097413	0	1,269,663	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.165978	0	4,696	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.191434	0	92,330	0	0	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0.159192	0	13,412	0	0	54.02
57.00	05700	CT SCAN	0.163530	0	71,395	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.453029	0	22,162	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.101510	0	278,068	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.259103	0	23,758	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.320453	0	5,499	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.190421	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.192162	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.016379	0	3,436	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.125854	0	226,725	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.380484	0	80,948	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.288368	0	96,960	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.137453	0	1,035,558	0	0	75.00
76.00	03330	ENDOSCOPY	0.102035	0	205,428	0	0	76.00
76.01	03020	WOUND CARE	0.177104	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.107572	0	572,794	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.320133	0	109,003	0	0	92.00
200.00		Subtotal (see instructions)		0	4,111,835	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	4,111,835	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Prepared: 11/21/2022 9:16 am
		Title XIX	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	123,682	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	779	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	17,675	0	54.00
54.01	03480 ONCOLOGY	0	0	54.01
54.02	05402 ULTRASOUND	2,135	0	54.02
57.00	05700 CT SCAN	11,675	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	10,040	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	28,227	0	60.00
65.00	06500 RESPIRATORY THERAPY	6,156	0	65.00
66.00	06600 PHYSICAL THERAPY	1,762	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	56	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	28,534	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	30,799	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	27,960	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	142,341	0	75.00
76.00	03330 ENDOSCOPY	20,961	0	76.00
76.01	03020 WOUND CARE	0	0	76.01
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	61,617	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	34,895	0	92.00
200.00	Subtotal (see instructions)	549,294	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (Line 200 - Line 201)	549,294	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepared: 11/21/2022 9:16 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)		17,442	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		17,442	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)		14,866	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)		3,444	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)		24,880,390	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)		24,880,390	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)		24,880,390	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)		1,426.46	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,912,728	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)		4,912,728	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepared: 11/21/2022 9:16 am	
Cost Center Description			Title XVIII		Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,895,923	2,281	2,584.80	1,221	3,156,041
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	NEONATAL INTENSIVE CARE UNIT	4,365,047	2,339	1,866.20	0	0
Cost Center Description						
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				8,334,935	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				16,403,704	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)				811,729	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				611,562	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				1,423,291	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				14,980,413	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)				0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	57.00
58.00	Bonus payment (see instructions)				0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0	61.00
62.00	Relief payment (see instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				2,576	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,426.46	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				3,674,561	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0157		Period: From 07/01/2021 To 06/30/2022		Worksheet D-1 Date/Time Prepared: 11/21/2022 9:16 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	2,791,185	24,880,390	0.112184	3,674,561	412,227	90.00
91.00	Nursing Program cost	0	24,880,390	0.000000	3,674,561	0	91.00
92.00	Allied health cost	0	24,880,390	0.000000	3,674,561	0	92.00
93.00	All other Medical Education	0	24,880,390	0.000000	3,674,561	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepared: 11/21/2022 9:16 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)		17,442	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		17,442	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)		14,866	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)		306	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)		3,046	15.00
16.00	Nursery days (title V or XIX only)		81	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)		24,880,390	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)		24,880,390	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)		24,880,390	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)		1,426.46	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		436,497	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)		436,497	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepared: 11/21/2022 9:16 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)	3,111,654	3,046	1,021.55	81	82,746	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	5,895,923	2,281	2,584.80	161	416,153	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	NEONATAL INTENSIVE CARE UNIT	4,365,047	2,339	1,866.20	558	1,041,340	47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					619,708	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,596,444	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,576	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,426.46	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,674,561	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0157		Period: From 07/01/2021 To 06/30/2022		Worksheet D-1 Date/Time Prepared: 11/21/2022 9:16 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	2,791,185	24,880,390	0.112184	3,674,561	412,227	90.00
91.00	Nursing Program cost	0	24,880,390	0.000000	3,674,561	0	91.00
92.00	Allied health cost	0	24,880,390	0.000000	3,674,561	0	92.00
93.00	All other Medical Education	0	24,880,390	0.000000	3,674,561	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet D-3 Date/Time Prepared: 11/21/2022 9:16 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		13,462,066	30.00
31.00	03100	INTENSIVE CARE UNIT		4,368,957	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	35.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.097413	16,457,105	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.165989	3,183	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.191756	1,126,756	54.00
54.01	03480	ONCOLOGY	0.000000	0	54.01
54.02	05402	ULTRASOUND	0.159192	214,950	54.02
57.00	05700	CT SCAN	0.163530	825,920	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.453029	67,376	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.101510	6,930,620	60.00
65.00	06500	RESPIRATORY THERAPY	0.259103	1,977,497	65.00
66.00	06600	PHYSICAL THERAPY	0.320453	684,297	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.190421	62,841	68.00
69.00	06900	ELECTROCARDIOLOGY	0.192162	485,071	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.016379	277,837	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.125854	3,026,020	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.380484	5,442,193	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.288368	5,427,501	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.137453	0	75.00
76.00	03330	ENDOSCOPY	0.102035	620,533	76.00
76.01	03020	WOUND CARE	0.177104	88,968	76.01
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.107572	3,811,224	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.320133	827,196	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		48,357,088	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)		48,357,088	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet D-3 Date/Time Prepared: 11/21/2022 9:16 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		1,217,194	30.00
31.00	03100	INTENSIVE CARE UNIT		1,196,648	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		859,000	35.00
43.00	04300	NURSERY		319,013	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.097413	754,923	73,539 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.165978	240,487	39,916 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.191434	60,016	11,489 54.00
54.01	03480	ONCOLOGY	0.000000	0	0 54.01
54.02	05402	ULTRASOUND	0.159192	32,759	5,215 54.02
57.00	05700	CT SCAN	0.163530	54,673	8,941 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.453029	5,787	2,622 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.101510	867,994	88,110 60.00
65.00	06500	RESPIRATORY THERAPY	0.259103	351,384	91,045 65.00
66.00	06600	PHYSICAL THERAPY	0.320453	33,094	10,605 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.190421	4,438	845 68.00
69.00	06900	ELECTROCARDIOLOGY	0.192162	42,151	8,100 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.016379	2,259	37 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.125854	191,634	24,118 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.380484	73,311	27,894 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.288368	603,127	173,923 73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.137453	0	0 75.00
76.00	03330	ENDOSCOPY	0.102035	90,307	9,214 76.00
76.01	03020	WOUND CARE	0.177104	0	0 76.01
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.107572	409,914	44,095 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.320133	0	0 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,818,258	619,708 200.00
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)		3,818,258	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part A Date/Time Prepared: 11/21/2022 9:16 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)		3,188,311	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		8,550,760	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)		137,114	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		293,431	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)		113.94	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)		1.55	30.00
31.00	Percentage of Medicaid patient days (see instructions)		18.85	31.00
32.00	Sum of lines 30 and 31		20.40	32.00
33.00	Allowable disproportionate share percentage (see instructions)		6.05	33.00
34.00	Disproportionate share adjustment (see instructions)		177,553	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part A Date/Time Prepared: 11/21/2022 9:16 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)	0.000252548	0.000162310	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,093,629	1,167,337	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	527,710	873,104	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,400,814		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)	13,747,983		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)		13,747,983	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		994,943	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		200,050	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		14,942,976	59.00
60.00	Primary payer payments		16,553	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		14,926,423	61.00
62.00	Deductibles billed to program beneficiaries		1,167,304	62.00
63.00	Coinurance billed to program beneficiaries		38,101	63.00
64.00	Allowable bad debts (see instructions)		69,275	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		45,029	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		16,892	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		13,766,047	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)		-11,433	70.93
70.94	HRR adjustment amount (see instructions)		-12,179	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part A Date/Time Prepared: 11/21/2022 9:16 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)		13,742,435	71.00
71.01	Sequestration adjustment (see instructions)		34,356	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		13,400,813	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		307,266	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		172,728	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. 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: 15-0157

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/21/2022 9:16 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	3,188,311	0	3,188,311		3,188,311	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	8,550,760	0		8,550,760	8,550,760	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	137,114	0	137,114		137,114	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	293,431	0		293,431	293,431	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	0.0605	0.0605	0.0605	0.0605		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	177,553	0	48,223	129,330	177,553	11.00
11.01	Uncompensated care payments	36.00	1,400,814	0	527,710	873,104	1,400,814	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	13,747,983	0	3,901,358	9,846,625	13,747,983	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	13,747,983	0	3,901,358	9,846,625	13,747,983	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	994,943	0	276,767	718,176	994,943	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0157

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/21/2022 9:16 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	200,050	0	96,679	103,371	200,050	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	4,274,804	10,668,172	14,942,976	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	893,865	0	245,305	648,560	893,865	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	63,357	0	21,110	42,247	63,357	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	0.0422	0.0422	0.0422	0.0422		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	37,721	0	10,352	27,369	37,721	25.00
26.00	Total prospective capital payments (see instructions)	12.00	994,943	0	276,767	718,176	994,943	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: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/21/2022 9:16 am
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		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. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,188,311	3,188,311		3,188,311	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	8,550,760		8,550,760	8,550,760	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	137,114	137,114		137,114	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	293,431		293,431	293,431	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	0.0605	0.0605	0.0605		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	177,553	48,223	129,330	177,553	11.00
11.01	Uncompensated care payments	36.00	1,400,814	527,710	873,104	1,400,814	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	13,747,983	3,901,358	9,846,625	13,747,983	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	13,747,983	3,901,358	9,846,625	13,747,983	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	994,943	276,767	718,176	994,943	16.00
17.00	Special add-on payments for new technologies	54.00	200,050	96,679	103,371	200,050	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			4,274,804	10,668,172	14,942,976	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/21/2022 9:16 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	893,865	245,305	648,560	893,865	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	63,357	21,110	42,247	63,357	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	0.0422	0.0422	0.0422		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	37,721	10,352	27,369	37,721	25.00
26.00	Total prospective capital payments (see instructions)	12.00	994,943	276,767	718,176	994,943	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	-11,433	-11,433	0	-11,433	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	-12,179	-5,256	-6,923	-12,179	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: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part B Date/Time Prepared: 11/21/2022 9:16 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		927	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		7,494,335	2.00
3.00	OPPS payments		6,388,345	3.00
4.00	Outlier payment (see instructions)		57,182	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		927	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		3,214	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)		3,214	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)		3,214	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		2,287	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)		927	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)		6,445,527	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)		1,179,581	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)		5,266,873	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)		5,266,873	30.00
31.00	Primary payer payments		209	31.00
32.00	Subtotal (line 30 minus line 31)		5,266,664	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)		76,900	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		49,985	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		43,205	36.00
37.00	Subtotal (see instructions)		5,316,649	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		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)		5,316,649	40.00
40.01	Sequestration adjustment (see instructions)		13,292	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		5,252,166	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)		51,191	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part B Date/Time Prepared: 11/21/2022 9:16 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: 15-0157		Period: From 07/01/2021 To 06/30/2022		Worksheet E-1 Part I Date/Time Prepared: 11/21/2022 9:16 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		13,400,813		5,252,166	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)		13,400,813		5,252,166	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		307,266		51,191	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		13,708,079		5,303,357	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet E-1 Part II Date/Time Prepared: 11/21/2022 9:16 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: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part VII Date/Time Prepared: 11/21/2022 9:16 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		2,596,444		1.00
2.00	Medical and other services			549,294	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		2,596,444	549,294	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		2,596,444	549,294	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		3,818,258	4,111,835	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)		3,818,258	4,111,835	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)		3,818,258	4,111,835	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,221,814	3,562,541	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)		2,596,444	549,294	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)		2,596,444	549,294	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)		2,596,444	549,294	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)		2,596,444	549,294	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		2,596,444	549,294	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)		2,596,444	549,294	40.00
41.00	Interim payments		2,596,444	549,294	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

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

Provider CCN: 15-0157

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

Worksheet G
Date/Time Prepared:
11/21/2022 9:16 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	9,443,645	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	68,762,066	0	0	0	4.00
5.00	Other receivable	1,404,261	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-33,587,056	0	0	0	6.00
7.00	Inventory	3,103,011	0	0	0	7.00
8.00	Prepaid expenses	193,530	0	0	0	8.00
9.00	Other current assets	233,937	0	0	0	9.00
10.00	Due from other funds	14,107,572	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	63,660,966	0	0	0	11.00
FIXED ASSETS						
12.00	Land	15,561,757	0	0	0	12.00
13.00	Land improvements	3,907,457	0	0	0	13.00
14.00	Accumulated depreciation	-2,698,931	0	0	0	14.00
15.00	Buildings	84,066,107	0	0	0	15.00
16.00	Accumulated depreciation	-56,285,798	0	0	0	16.00
17.00	Leasehold improvements	3,282,206	0	0	0	17.00
18.00	Accumulated depreciation	-2,836,389	0	0	0	18.00
19.00	Fixed equipment	18,902,395	0	0	0	19.00
20.00	Accumulated depreciation	-8,443,713	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	55,994,734	0	0	0	23.00
24.00	Accumulated depreciation	-44,438,494	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)	67,011,331	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	330,976	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	32,176,803	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	32,176,803	330,976	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	162,849,100	330,976	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,995,513	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,496,633	0	0	0	38.00
39.00	Payroll taxes payable	491,166	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	15,425,877	0	0	0	43.00
44.00	Other current liabilities	15,211,811	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	35,621,000	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	27,297,286	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	27,297,286	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	62,918,286	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	99,930,814	0	0	0	52.00
53.00	Specific purpose fund	0	330,976	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)	99,930,814	330,976	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	162,849,100	330,976	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0157

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

Worksheet G-1

Date/Time Prepared:
11/21/2022 9:16 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		98,980,715		283,704	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		89,439,978			2.00
3.00	Total (sum of line 1 and line 2)		188,420,693		283,704	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00	OTHER ACTIVITY	15,472,555		17,822		5.00
6.00	OTHER ADJUSTMENT (NET INCOME/LOSS NO	0		-17,299		6.00
7.00	TEMP RESTRICTED OTHER	0		46,750		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		15,472,555		47,273	10.00
11.00	Subtotal (line 3 plus line 10)		203,893,248		330,977	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00	DISTRIBUTIONS	14,352,951		0		13.00
14.00	NET ASSET TRANS TO FROM ALPHA	89,609,484		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00	ROUNDING	-1		1		17.00
18.00	Total deductions (sum of lines 12-17)		103,962,434		1	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		99,930,814		330,976	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	OTHER ACTIVITY		0			5.00
6.00	OTHER ADJUSTMENT (NET INCOME/LOSS NO		0			6.00
7.00	TEMP RESTRICTED OTHER		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	DISTRIBUTIONS		0			13.00
14.00	NET ASSET TRANS TO FROM ALPHA		0			14.00
15.00			0			15.00
16.00			0			16.00
17.00	ROUNDING		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: 15-0157

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/21/2022 9:16 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	63,746,484		63,746,484	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				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)	63,746,484		63,746,484	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	18,381,368		18,381,368	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	NEONATAL INTENSIVE CARE UNIT	21,400,641		21,400,641	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	39,782,009		39,782,009	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	103,528,493		103,528,493	17.00
18.00	Ancillary services	199,912,331	426,686,794	626,599,125	18.00
19.00	Outpatient services	12,735,545	49,682,909	62,418,454	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PRIVATE OFFICES	0	583,286	583,286	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	316,176,369	476,952,989	793,129,358	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		167,270,225		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)		167,270,225		43.00

STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet G-3 Date/Time Prepared: 11/21/2022 9:16 am
				1.00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			793,129,358 1.00
2.00	Less contractual allowances and discounts on patients' accounts			543,630,697 2.00
3.00	Net patient revenues (line 1 minus line 2)			249,498,661 3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			167,270,225 4.00
5.00	Net income from service to patients (line 3 minus line 4)			82,228,436 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		329,133	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		224,708	16.00
17.00	Revenue from sale of drugs to other than patients		0	17.00
18.00	Revenue from sale of medical records and abstracts		0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)		0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen		0	20.00
21.00	Rental of vending machines		6,361	21.00
22.00	Rental of hospital space		788,489	22.00
23.00	Governmental appropriations		0	23.00
24.00	OTHER (SPECIFY)		0	24.00
24.01	CONTRACT SERVICES REVENUE		0	24.01
24.02	OTHER MISCELLANEOUS REVENUE		1,228,239	24.02
24.03	OTHER (SPECIFY)		0	24.03
24.04	LATE PENALTY FEES		3,516	24.04
24.05	OTHER (SPECIFY)		0	24.05
24.06	CONSOLIDATING AMOUNT (NEEDS TO BE OF		1,230,509	24.06
24.07	OTHER (SPECIFY)		0	24.07
24.08	SEMINARS TUITION REVENUE		0	24.08
24.09	MEDICAL AFFAIRS ADMIN - ADMINISTRATION		124,095	24.09
24.10	UNCLAIMED PROPERTY EXCEPTION		219,016	24.10
24.11	INTRA/INTERCOMPANY OPERATING REVENUE		39,136	24.11
24.12	AUXILIARY/GIFT SHOP INCOME		1,414,344	24.12
24.13	BILLING ARRANGEMENTS		0	24.13
24.14	UNRESTRICTED DONATIONS REVENUE		101,336	24.14
24.15	ON SITE CLINICS OTHER REVENUE		0	24.15
24.16	ACCOMMODATION FEES		5,110	24.16
24.17	FOUNDATION TRANSFERS		20,454	24.17
24.18	PATIENT INTEREST INCOME		0	24.18
24.19	REVENUES FROM EXTERNAL PARTIES		391,873	24.19
24.20	GAIN ON SALE DISPOSAL PPE		0	24.20
24.21	HHS STIMULUS OP REV 30B		800	24.21
24.50	COVID-19 PHE Funding		1,084,423	24.50
25.00	Total other income (sum of lines 6-24)		7,211,542	25.00
26.00	Total (line 5 plus line 25)		89,439,978	26.00
27.00	OTHER EXPENSES (SPECIFY)		0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)		0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)		89,439,978	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0157	Period: From 07/01/2021 To 06/30/2022	Worksheet L Parts I-III Date/Time Prepared: 11/21/2022 9:16 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		893,865	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		63,357	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)		58.56	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)		1.55	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		18.85	8.00
9.00	Sum of lines 7 and 8		20.40	9.00
10.00	Allowable disproportionate share percentage (see instructions)		4.22	10.00
11.00	Disproportionate share adjustment (see instructions)		37,721	11.00
12.00	Total prospective capital payments (see instructions)		994,943	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