

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: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet S Parts I-III Date/Time Prepared: 11/29/2022 10:58 am
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PART I - COST REPORT STATUS

Provider use only
 1. Electronically prepared cost report
 2. Manually prepared cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only
 5. 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. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN
 10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 11/29/2022 Time: 10:58 am

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 WARRICK (15-1325) 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	Zach Zirkelbach	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Zach Zirkelbach		2
3	Signatory Title	VP OF FINANCE		3
4	Date	11/29/2022 10:58:00 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	72,823	-161,856	0	0	1.00
2.00 Subprovider - IPF	0	14,437	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I						4.00
5.00 Swing Bed - SNF	0	215,899	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
200.00 Total	0	303,159	-161,856	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: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part I Date/Time Prepared: 11/29/2022 10:58 am
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1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1116 MILLIS AVE			PO Box:						1.00	
2.00	City: BOONEVILLE			State: IN		Zip Code: 47601		County: WARRICK		2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		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 WARRICK	151325	21780	1	03/01/2005	N	O	O	3.00
4.00	Subprovider - IPF		ST. VINCENT WARRICK - PSYCH UNIT	15M325	21780	4	03/01/2005	N	P	O	4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF		ST. VINCENT WARRICK - SWING BED	15Z325	21780		03/01/2005	N	O	N	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.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			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.						2	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1325			Period: From 07/01/2021 To 06/30/2022		Worksheet S-2 Part I Date/Time Prepared: 11/29/2022 10:58 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.	0	0	0	0	0	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	0		25.00
						Urban/Rural	S	Date of Geogr	
						1.00		2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00
						V	XVII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR 412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.								58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00

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		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	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.			Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	N	0	71.00
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)			N	N	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	XIX		
			1.00	2.00		
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	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?		Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00	
			Physical	Occupational	Speech	Respiratory
			1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	N	N
					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: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part I Date/Time Prepared: 11/29/2022 10:58 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:	127,780	0	118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.04	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 COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part I Date/Time Prepared: 11/29/2022 10:58 am
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		1.00	2.00	3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name: ASCENSION ST. VINCENT HEALTH	Contractor's Name: WPS		Contractor's Number: 08001			141.00	
142.00	Street: 250 WEST 96TH STREET, SUITE 215	PO Box:					142.00	
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46260				143.00	
							1.00	
144.00	Are provider based physicians' costs included in Worksheet A?						Y	144.00
							1.00	
							2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.						N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							146.00
							1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N		155.00	
156.00	Subprovider - IPF	N	N	N	N		156.00	
157.00	Subprovider - IRF	N	N	N	N		157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00	
161.00	CMHC		N	N	N		161.00	
							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
		Beginning		Ending				
		1.00		2.00				
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00
							1.00	
							2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1325		Period: From 07/01/2021 To 06/30/2022		Worksheet S-2 Part II Date/Time Prepared: 11/29/2022 10:58 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			Y			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
						Y/N	
						1.00	
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	10/07/2022	Y	10/07/2022
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part II Date/Time Prepared: 11/29/2022 10:58 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL		HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ASCENSION			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	N/A		JILL.HILL@ASCENSION.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-1325

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

Worksheet S-2
Part II
Date/Time Prepared:
11/29/2022 10:58 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: 15-1325

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

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2022 10:58 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	25	9,125	6,552.00	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)		25	9,125	6,552.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	6,552.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						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)		35			0	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: 15-1325

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

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2022 10:58 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)	135	3	273			1.00
2.00 HMO and other (see instructions)	105	30				2.00
3.00 HMO IPF Subprovider	192	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	709	0	1,812			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	250			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	844	3	2,335			7.00
8.00 INTENSIVE CARE UNIT	0	0	0			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	844	3	2,335	0.00	68.19	14.00
15.00 CAH visits	6,430	295	26,143			15.00
16.00 SUBPROVIDER - IPF	1,747	0	1,962	0.00	12.27	16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER		0	0	0.00	0.00	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	80.46	27.00
28.00 Observation Bed Days		0	351			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			71			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			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: 15-1325

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

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2022 10:58 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	40	2	104	1.00
2.00	HMO and other (see instructions)			25	10		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	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	40	2	104	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	112	0	130	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY						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 UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet S-10 Date/Time Prepared: 11/29/2022 10:58 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)		0.327262	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		376,212	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		11,760,533	6.00	
7.00	Medicaid cost (line 1 times line 6)		3,848,776	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)		3,472,564	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)		3,472,564	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)	538,879	323,087	861,966	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	176,355	323,087	499,442	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)	176,355	323,087	499,442	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)			1,112,392	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			133,632	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			205,587	27.01
28.00	Non-Medicare bad debt expense (see instructions)			906,805	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			368,718	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			868,160	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			4,340,724	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-1325		Period: From 07/01/2021 To 06/30/2022		Worksheet A	
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		149,669	149,669	0	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	106,804	1,672,263	1,779,067	0	4.00
5.02	00560	PURCHASING RECEIVING AND STORES	0	16,560	16,560	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,146	16,185	18,331	0	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	596,222	5,333,080	5,929,302	-150,012	5.04
7.00	00700	OPERATION OF PLANT	0	1,006,505	1,006,505	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	24,940	24,940	0	8.00
9.00	00900	HOUSEKEEPING	0	309,756	309,756	0	9.00
10.00	01000	DIETARY	0	482,439	482,439	-209,024	10.00
11.00	01100	CAFETERIA	0	0	0	209,024	11.00
13.00	01300	NURSING ADMINISTRATION	158,546	89,742	248,288	150,012	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	253,610	-40,786	212,824	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,287,345	66,775	1,354,120	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	1,062,025	871,232	1,933,257	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	368,086	669,005	1,037,091	-155,171	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	652,437	583,779	1,236,216	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	118,577	1,349,942	1,468,519	0	60.00
65.00	06500	RESPIRATORY THERAPY	251,657	19,607	271,264	0	65.00
66.00	06600	PHYSICAL THERAPY	262,012	7,937	269,949	-106,305	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	92,853	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	13,452	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	49,787	49,787	155,171	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32,571	32,571	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	297,643	297,643	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,016,927	1,699,725	2,716,652	0	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)	6,136,394	14,708,356	20,844,750	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	1,773	1,773	0	194.00
194.01	07951	OTHER NRCC - WIC	420,165	183,272	603,437	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	0	0	194.03
194.04	07954	OTHER NRCC - MARKETING	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	6,556,559	14,893,401	21,449,960	0	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-1325

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

Worksheet A
Date/Time Prepared:
11/29/2022 10:58 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	39,215	39,215	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-118,250	31,419	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	61,080	1,840,147	4.00
5.02	00560	PURCHASING RECEIVING AND STORES	-5	16,555	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	18,331	5.03
5.04	00590	OTHER ADMINISTRATION AND GENERAL	1,271,998	7,051,288	5.04
7.00	00700	OPERATION OF PLANT	0	1,006,505	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	24,940	8.00
9.00	00900	HOUSEKEEPING	0	309,756	9.00
10.00	01000	DIETARY	-34	273,381	10.00
11.00	01100	CAFETERIA	-40,363	168,661	11.00
13.00	01300	NURSING ADMINISTRATION	-2,034	396,266	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	212,824	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,354,120	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
40.00	04000	SUBPROVIDER - I PF	-5,098	1,928,159	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-182,799	699,121	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-77,306	1,158,910	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-2,025	1,466,494	60.00
65.00	06500	RESPIRATORY THERAPY	0	271,264	65.00
66.00	06600	PHYSICAL THERAPY	-3,900	159,744	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	92,853	67.00
68.00	06800	SPEECH PATHOLOGY	0	13,452	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-42,426	162,532	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32,571	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	297,643	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-802,030	1,914,622	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)	96,023	20,940,773	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	1,773	194.00
194.01	07951	OTHER NRCC - WIC	0	603,437	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	194.03
194.04	07954	OTHER NRCC - MARKETING	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	96,023	21,545,983	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - Nursing Admin Salaries					
1.00	NURSING ADMINISTRATION	13.00	150,012	0	1.00
	TOTALS		150,012	0	
B - Cafeteria Expense					
1.00	CAFETERIA	11.00	0	209,024	1.00
				209,024	
C - Supplies and Implantable Devices					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	155,171	1.00
				155,171	
D - Therapy Costs					
1.00	OCCUPATIONAL THERAPY	67.00	89,662	3,191	1.00
2.00	SPEECH PATHOLOGY	68.00	13,123	329	2.00
			102,785	3,520	
500.00	Grand Total: Increases		252,797	367,715	500.00

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - Nursing Admin Salaries						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	150,012	0	0	1.00
	TOTALS		150,012	0		
B - Cafeteria Expense						
1.00	DIETARY	10.00	0	209,024		1.00
				209,024		
C - Supplies and Implantable Devices						
1.00	OPERATING ROOM	50.00	0	155,171		1.00
				155,171		
D - Therapy Costs						
1.00	PHYSICAL THERAPY	66.00	102,785	3,520		1.00
2.00			102,785	3,520		2.00
500.00	Grand Total: Decreases		252,797	367,715		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1325

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

Worksheet A-7
Part I
Date/Time Prepared:
11/29/2022 10:58 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	453,038	355,725	0	355,725	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	13,987,837	393,334	0	393,334	0	3.00
4.00	Building Improvements	153,762	10,612	0	10,612	0	4.00
5.00	Fixed Equipment	10,209,377	341,901	0	341,901	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,804,014	1,101,572	0	1,101,572	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	24,804,014	1,101,572	0	1,101,572	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	808,763	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	14,381,171	0				3.00
4.00	Building Improvements	164,374	0				4.00
5.00	Fixed Equipment	10,551,278	0				5.00
6.00	Movable Equipment	0	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	25,905,586	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	25,905,586	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1325

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

Worksheet A-7
Part II
Date/Time Prepared:
11/29/2022 10:58 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	31,419	118,250	0	0	2.00
3.00	Total (sum of lines 1-2)	0	31,419	118,250	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	149,669				2.00
3.00	Total (sum of lines 1-2)	0	149,669				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1325

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

Worksheet A-7
Part III
Date/Time Prepared:
11/29/2022 10:58 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	15,189,934	0	15,189,934	0.586357	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,715,652	0	10,715,652	0.413643	0	2.00
3.00	Total (sum of lines 1-2)	25,905,586	0	25,905,586	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	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	31,419	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	31,419	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	39,215	0	0	0	39,215	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	31,419	2.00
3.00	Total (sum of lines 1-2)	39,215	0	0	0	70,634	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-1325

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

Worksheet A-8

Date/Time Prepared:
11/29/2022 10:58 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	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-20,561	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	-1,437	OTHER ADMINISTRATIVE AND GENERAL	5.04		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)		0		0.00		8.00
9.00 Parking lot (chapter 21)		0		0.00		9.00
10.00 Provider-based physician adjustment	A-8-2	-1,061,916				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	2,615,363				12.00
13.00 Laundry and linen service		0		0.00		13.00
14.00 Cafeteria-employees and guests	B	-40,363	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		0		0.00		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	-34	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

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-1325

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

Worksheet A-8

Date/Time Prepared:
11/29/2022 10:58 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		
33.00 Other Admin-Medical Records	B	-50	OTHER ADMIN STRATIVE AND GENERAL	5.04	0	33.00
33.01 Miscellaneous Lab Revenue	B	-930	LABORATORY	60.00	0	33.01
33.02 Fitness Club Revenue	B	-3,900	PHYSICAL THERAPY	66.00	0	33.02
33.03 ED Revenue	B	-1,314	EMERGENCY	91.00	0	33.03
33.05 Late Penalty Fees	A	-5	PURCHASING RECEIVING AND STORES	5.02	0	33.05
33.06 Sponsorship, Marketing, Charity	A	-5,707	OTHER ADMIN STRATIVE AND GENERAL	5.04	0	33.06
33.07 Physician Fund	A	-18,795	OTHER ADMIN STRATIVE AND GENERAL	5.04	0	33.07
33.08 Psych Marketing	A	-1,639	SUBPROVIDER - IPF	40.00	0	33.08
33.09 Non-allowable CED Salaries	A	-3,459	SUBPROVIDER - IPF	40.00	0	33.09
33.10 Non-allowable CED Benefits	A	-969	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11 Provider Tax Expense	A	-1,300,635	OTHER ADMIN STRATIVE AND GENERAL	5.04	0	33.11
33.13 Unnecessary Borrowing	A	-57,133	CAP REL COSTS-BLDG & FIXT	1.00	11	33.13
33.15 Lobbying Offset	A	-493	OTHER ADMIN STRATIVE AND GENERAL	5.04	0	33.15
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		96,023				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: 15-1325
 Period: From 07/01/2021 To 06/30/2022
 Worksheet A-8-1
 Date/Time Prepared: 11/29/2022 10:58 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.04	OTHER ADMINISTRATIVE AND GEN	Home Office Capital	341,480	0 1.00
2.00	5.04	OTHER ADMINISTRATIVE AND GEN	Home Office Interest - Capital	7,520	0 2.00
3.00	5.04	OTHER ADMINISTRATIVE AND GEN	Home Office Interest - A&G	45	0 3.00
3.01	5.04	OTHER ADMINISTRATIVE AND GEN	Home Office - Other	5,918,088	3,624,653 3.01
3.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	Health Insurance	1,098,979	1,036,930 3.02
3.03	1.00	CAP REL COSTS-BLDG & FIXT	Interest Expense	116,909	0 3.03
3.04	2.00	CAP REL COSTS-MVBLE EQUIP	Interest Expense	0	118,250 3.04
3.05	5.04	OTHER ADMINISTRATIVE AND GEN	Interest Expense	604	0 3.05
3.06	71.00	MEDICAL SUPPLIES CHARGED TO	TRG Admin Fees - Supplies	-42,426	0 3.06
3.07	13.00	NURSING ADMINISTRATION	TRG Admin Fees - Contracted	-2,034	0 3.07
3.08	5.04	OTHER ADMINISTRATIVE AND GEN	TRG Admin Fees - Other	-43,969	0 3.08
4.00	0.00			0	0 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,395,196	4,779,833 5.00

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

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

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

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

6.00	B	ASCENSION SVH	100.00	ASCENSION SVH	100.00	6.00
7.00	B	ASCENSION	100.00	ASCENSION	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 15-1325

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

Worksheet A-8-1

Date/Time Prepared:
11/29/2022 10:58 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	341,480	0		1.00
2.00	7,520	0		2.00
3.00	45	0		3.00
3.01	2,293,435	0		3.01
3.02	62,049	0		3.02
3.03	116,909	11		3.03
3.04	-118,250	11		3.04
3.05	604	0		3.05
3.06	-42,426	0		3.06
3.07	-2,034	0		3.07
3.08	-43,969	0		3.08
4.00	0	0		4.00
5.00	2,615,363			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: 15-1325

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

Worksheet A-8-2

Date/Time Prepared:
11/29/2022 10:58 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	50.00	OPERATING ROOM	148,428	25,358	123,070	0	0	1.00
2.00	50.00	OPERATING ROOM	157,441	157,441	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	77,306	77,306	0	0	0	4.00
5.00	60.00	LABORATORY	1,095	1,095	0	0	0	5.00
6.00	91.00	EMERGENCY	283,727	283,727	0	0	0	6.00
7.00	91.00	EMERGENCY	1,323,030	516,989	806,041	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,991,027	1,061,916	929,111			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	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	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	50.00	OPERATING ROOM	0	0	0	25,358	1.00
2.00	50.00	OPERATING ROOM	0	0	0	157,441	2.00
3.00	0.00		0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	77,306	4.00
5.00	60.00	LABORATORY	0	0	0	1,095	5.00
6.00	91.00	EMERGENCY	0	0	0	283,727	6.00
7.00	91.00	EMERGENCY	0	0	0	516,989	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	1,061,916	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1325

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

Worksheet B
Part I
Date/Time Prepared:
11/29/2022 10:58 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	PURCHASING RECEIVING AND STORES	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.02	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	39,215	39,215			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	31,419		31,419		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,840,147	371	297	1,840,815	4.00
5.02 00560	PURCHASING RECEIVING AND STORES	16,555	697	558		5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	18,331	1,246	998	612	5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	7,051,288	5,195	4,161	127,352	5.04
7.00 00700	OPERATION OF PLANT	1,006,505	2,852	2,285	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	24,940	292	234	0	8.00
9.00 00900	HOUSEKEEPING	309,756	710	569	0	9.00
10.00 01000	DIETARY	273,381	1,657	1,327	0	10.00
11.00 01100	CAFETERIA	168,661	603	483	0	11.00
13.00 01300	NURSING ADMINISTRATION	396,266	138	111	88,065	13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	0	449	360	0	14.00
15.00 01500	PHARMACY	212,824	634	508	72,383	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	941	754	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,354,120	4,920	3,942	367,419	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00 04000	SUBPROVIDER - IPF	1,928,159	3,503	2,807	303,111	40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	699,121	3,097	2,481	105,055	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,158,910	2,376	1,904	186,211	54.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	1,466,494	1,239	993	33,843	60.00
65.00 06500	RESPIRATORY THERAPY	271,264	500	401	71,825	65.00
66.00 06600	PHYSICAL THERAPY	159,744	1,388	1,112	45,445	66.00
67.00 06700	OCCUPATIONAL THERAPY	92,853	819	656	25,590	67.00
68.00 06800	SPEECH PATHOLOGY	13,452	21	17	3,745	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	162,532	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	32,571	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	297,643	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	1,914,622	1,840	1,474	290,240	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)	20,940,773	35,488	28,432	1,720,896	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	224	180	0	190.00
194.00 07950	OTHER NRCC - PHYSICIAN CLINIC	1,773	2,138	1,713	0	194.00
194.01 07951	OTHER NRCC - WIC	603,437	0	0	119,919	194.01
194.02 07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	194.02
194.03 07953	OTHER NRCC - DR. OFFICE	0	1,365	1,094	0	194.03
194.04 07954	OTHER NRCC - MARKETING	0	0	0	0	194.04
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)	21,545,983	39,215	31,419	1,840,815	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet B Part I Date/Time Prepared: 11/29/2022 10:58 am		
Cost Center	Description	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.03	5A.03	5.04	7.00	8.00	
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
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	21,187				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	7,187,996	7,187,996		5.04
7.00	00700	OPERATION OF PLANT	0	1,011,642	506,455	1,518,097	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	25,466	12,749	15,353	8.00
9.00	00900	HOUSEKEEPING	0	311,035	155,713	37,343	9.00
10.00	01000	DIETARY	0	276,365	138,356	87,171	10.00
11.00	01100	CAFETERIA	0	169,747	84,980	31,716	11.00
13.00	01300	NURSING ADMINISTRATION	0	484,580	242,594	7,266	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	809	405	23,630	14.00
15.00	01500	PHARMACY	0	286,786	143,573	33,382	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,695	849	49,527	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,376	1,740,933	871,558	258,834	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - I/PF	1,422	2,245,974	1,124,395	184,312	40.00
41.00	04100	SUBPROVIDER - I/RF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,711	811,665	406,341	162,923	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,947	1,356,677	679,189	125,006	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	3,509	1,506,098	753,993	65,207	60.00
65.00	06500	RESPIRATORY THERAPY	559	344,549	172,491	26,307	65.00
66.00	06600	PHYSICAL THERAPY	319	208,008	104,134	73,020	66.00
67.00	06700	OCCUPATIONAL THERAPY	235	120,153	60,152	43,080	67.00
68.00	06800	SPEECH PATHOLOGY	40	17,275	8,648	1,120	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	328	162,860	81,532	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	118	32,689	16,365	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	998	298,641	149,508	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,625	2,212,362	1,107,568	96,814	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)	21,187	20,814,005	6,821,548	1,322,011	53,568
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	404	202	11,801	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	5,624	2,816	112,467	194.00
194.01	07951	OTHER NRCC - WIC	0	723,491	362,199	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	2,459	1,231	71,818	194.03
194.04	07954	OTHER NRCC - MARKETING	0	0	0	0	194.04
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)	21,187	21,545,983	7,187,996	1,518,097	53,568

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-1325		Period: From 07/01/2021 To 06/30/2022		Worksheet B Part I Date/Time Prepared: 11/29/2022 10:58 am	
Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
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
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	507,286					9.00
10.00	01000	DIETARY	0	501,892				10.00
11.00	01100	CAFETERIA	2,644	0	289,087			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	14,012	748,452		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	24,844	14.00
15.00	01500	PHARMACY	8,753	0	8,161	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	547	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	171,328	293,213	59,701	257,916	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - I PF	121,050	208,679	50,670	202,016	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	16,595	0	18,831	53,424	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,642	0	30,620	251	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	21,974	0	11,277	915	0	60.00
65.00	06500	RESPIRATORY THERAPY	5,325	0	13,305	6,476	0	65.00
66.00	06600	PHYSICAL THERAPY	10,394	0	6,872	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,513	0	4,294	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	766	0	689	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	24,844	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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	47,577	0	38,523	165,204	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	447,108	501,892	256,955	686,202	24,844	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	36,289	0	0	0	0	194.00
194.01	07951	OTHER NRCC - WIC	23,889	0	32,132	62,250	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC - MARKETING	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	507,286	501,892	289,087	748,452	24,844	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1325

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

Worksheet B
Part I
Date/Time Prepared:
11/29/2022 10:58 am

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.02	00560						5.02
5.03	00580						5.03
5.04	00590						5.04
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500	480,655					15.00
16.00	01600		52,618				16.00
17.00	01700			0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	111	3,417	0	3,671,331	0	30.00
31.00	03100	0	0	0	0	0	31.00
40.00	04000	0	3,533	0	4,152,331	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	745	4,249	0	1,479,623	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	887	17,247	0	2,248,278	0	54.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	8,717	0	2,371,607	0	60.00
65.00	06500	0	1,389	0	570,181	0	65.00
66.00	06600	0	791	0	404,743	0	66.00
67.00	06700	0	584	0	236,877	0	67.00
68.00	06800	0	98	0	28,711	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	815	0	270,051	0	71.00
72.00	07200	0	292	0	49,346	0	72.00
73.00	07300	478,843	2,480	0	929,472	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	69	9,006	0	3,684,360	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00							118.00
		480,655	52,618	0	20,096,911	0	
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	12,407	0	190.00
194.00	07950	0	0	0	157,196	0	194.00
194.01	07951	0	0	0	1,203,961	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	75,508	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		480,655	52,618	0	21,545,983	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet B Part I Date/Time Prepared: 11/29/2022 10:58 am
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.02	00560 PURCHASING RECEIVING AND STORES		5.02
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE		5.03
5.04	00590 OTHER ADMINISTRATIVE AND GENERAL		5.04
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 SERVICE & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	3,671,331	30.00
31.00	03100 INTENSIVE CARE UNIT	0	31.00
40.00	04000 SUBPROVIDER - I PF	4,152,331	40.00
41.00	04100 SUBPROVIDER - I RF	0	41.00
42.00	04200 SUBPROVIDER	0	42.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	1,479,623	50.00
51.00	05100 RECOVERY ROOM	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300 ANESTHESIOLOGY	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,248,278	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	59.00
60.00	06000 LABORATORY	2,371,607	60.00
65.00	06500 RESPIRATORY THERAPY	570,181	65.00
66.00	06600 PHYSICAL THERAPY	404,743	66.00
67.00	06700 OCCUPATIONAL THERAPY	236,877	67.00
68.00	06800 SPEECH PATHOLOGY	28,711	68.00
69.00	06900 ELECTROCARDIOLOGY	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	270,051	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	49,346	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	929,472	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0	90.00
91.00	09100 EMERGENCY	3,684,360	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)	20,096,911	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,407	190.00
194.00	07950 OTHER NRCC - PHYSICIAN CLINIC	157,196	194.00
194.01	07951 OTHER NRCC - WIC	1,203,961	194.01
194.02	07952 OTHER NRCC - PUBLIC RELATIONS	0	194.02
194.03	07953 OTHER NRCC - DR. OFFICE	75,508	194.03
194.04	07954 OTHER NRCC - MARKETING	0	194.04
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	21,545,983	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet B Part II Date/Time Prepared: 11/29/2022 10:58 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	371	297	668	668 4.00
5.02 00560	PURCHASING RECEIVING AND STORES	0	697	558	1,255	0 5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,246	998	2,244	0 5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	399,798	5,195	4,161	409,154	46 5.04
7.00 00700	OPERATION OF PLANT	294,046	2,852	2,285	299,183	0 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	292	234	526	0 8.00
9.00 00900	HOUSEKEEPING	0	710	569	1,279	0 9.00
10.00 01000	DIETARY	2,341	1,657	1,327	5,325	0 10.00
11.00 01100	CAFETERIA	0	603	483	1,086	0 11.00
13.00 01300	NURSING ADMINISTRATION	5,715	138	111	5,964	32 13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	0	449	360	809	0 14.00
15.00 01500	PHARMACY	15,022	634	508	16,164	26 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	941	754	1,695	0 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	8,973	4,920	3,942	17,835	133 30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
40.00 04000	SUBPROVIDER - IPF	63,453	3,503	2,807	69,763	110 40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	118,051	3,097	2,481	123,629	38 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	362,191	2,376	1,904	366,471	68 54.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	0	1,239	993	2,232	12 60.00
65.00 06500	RESPIRATORY THERAPY	13,787	500	401	14,688	26 65.00
66.00 06600	PHYSICAL THERAPY	3,713	1,388	1,112	6,213	17 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	819	656	1,475	9 67.00
68.00 06800	SPEECH PATHOLOGY	0	21	17	38	1 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
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
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	13,023	1,840	1,474	16,337	106 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,300,113	35,488	28,432	1,364,033	624 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	224	180	404	0 190.00
194.00 07950	OTHER NRCC - PHYSICIAN CLINIC	166	2,138	1,713	4,017	0 194.00
194.01 07951	OTHER NRCC - WIC	62,920	0	0	62,920	44 194.01
194.02 07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0 194.02
194.03 07953	OTHER NRCC - DR. OFFICE	0	1,365	1,094	2,459	0 194.03
194.04 07954	OTHER NRCC - MARKETING	0	0	0	0	0 194.04
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	1,363,199	39,215	31,419	1,433,833	668 202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-1325		Period: From 07/01/2021 To 06/30/2022		Worksheet B Part II Date/Time Prepared: 11/29/2022 10:58 am	
Cost Center Description			PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5.03	5.04	7.00	8.00	
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
5.02	00560	PURCHASING RECEIVING AND STORES	1,255					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	2,244				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	0	409,200			5.04
7.00	00700	OPERATION OF PLANT	0	0	28,832	328,015		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	726	3,317	4,569	8.00
9.00	00900	HOUSEKEEPING	0	0	8,864	8,069	273	9.00
10.00	01000	DIETARY	0	0	7,876	18,835	0	10.00
11.00	01100	CAFETERIA	0	0	4,838	6,853	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	13,811	1,570	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	23	5,106	0	14.00
15.00	01500	PHARMACY	31	0	8,173	7,213	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	48	10,701	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	645	148	49,617	55,926	1,221	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - I/PF	491	153	64,009	39,824	998	40.00
41.00	04100	SUBPROVIDER - I/RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14	183	23,132	35,203	414	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23	717	38,665	27,010	491	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1	376	42,924	14,089	292	60.00
65.00	06500	RESPIRATORY THERAPY	0	60	9,820	5,684	29	65.00
66.00	06600	PHYSICAL THERAPY	0	34	5,928	15,777	130	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	25	3,424	9,308	94	67.00
68.00	06800	SPEECH PATHOLOGY	0	4	492	242	10	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	35	4,642	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13	932	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	107	8,511	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	40	389	63,052	20,919	617	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,245	2,244	388,339	285,646	4,569	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	12	2,550	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	0	160	24,301	0	194.00
194.01	07951	OTHER NRCC - WIC	10	0	20,619	0	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	70	15,518	0	194.03
194.04	07954	OTHER NRCC - MARKETING	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,255	2,244	409,200	328,015	4,569	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1325		Period: From 07/01/2021 To 06/30/2022		Worksheet B Part II Date/Time Prepared: 11/29/2022 10:58 am	
Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.02	00560						5.02
5.03	00580						5.03
5.04	00590						5.04
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	18,485					9.00
10.00	01000	0	32,036				10.00
11.00	01100	96	0	12,873			11.00
13.00	01300	0	0	624	22,001		13.00
14.00	01400	0	0	0	0	5,938	14.00
15.00	01500	319	0	363	0	0	15.00
16.00	01600	20	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	6,243	18,716	2,659	7,583	0	30.00
31.00	03100	0	0	0	0	0	31.00
40.00	04000	4,411	13,320	2,256	5,938	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	605	0	839	1,570	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	1,189	0	1,364	7	0	54.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	801	0	502	27	0	60.00
65.00	06500	194	0	592	190	0	65.00
66.00	06600	379	0	306	0	0	66.00
67.00	06700	274	0	191	0	0	67.00
68.00	06800	28	0	31	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	5,938	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	1,734	0	1,715	4,856	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		16,293	32,036	11,442	20,171	5,938	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	1,322	0	0	0	0	194.00
194.01	07951	870	0	1,431	1,830	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		18,485	32,036	12,873	22,001	5,938	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-1325		Period: From 07/01/2021 To 06/30/2022		Worksheet B Part II Date/Time Prepared: 11/29/2022 10:58 am	
Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
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 SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY	32,289					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,464				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7	809	0	161,542	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	837	0	202,110	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	50	1,007	0	186,684	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	60	4,087	0	440,152	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	2,065	0	63,321	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	329	0	31,612	0	65.00
66.00	06600	PHYSICAL THERAPY	0	187	0	28,971	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	138	0	14,938	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	23	0	869	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	193	0	10,808	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	69	0	1,014	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,167	587	0	41,372	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	5	2,133	0	111,903	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)	32,289	12,464	0	1,295,296	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	2,966	0	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	0	0	29,800	0	194.00
194.01	07951	OTHER NRCC - WIC	0	0	0	87,724	0	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	0	0	0	18,047	0	194.03
194.04	07954	OTHER NRCC - MARKETING	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	32,289	12,464	0	1,433,833	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet B Part II Date/Time Prepared: 11/29/2022 10:58 am
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.02	00560	PURCHASING RECEIVING AND STORES	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	5.04
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 SERVICE & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - I PF	40.00
41.00	04100	SUBPROVIDER - I RF	41.00
42.00	04200	SUBPROVIDER	42.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	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)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	194.00
194.01	07951	OTHER NRCC - WIC	194.01
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	194.02
194.03	07953	OTHER NRCC - DR. OFFICE	194.03
194.04	07954	OTHER NRCC - MARKETING	194.04
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1325

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

Worksheet B-1

Date/Time Prepared:
11/29/2022 10:58 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	75,527				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		75,527			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	714	714	6,449,755		4.00
5.02 00560	PURCHASING RECEIVING AND STORES	1,342	1,342	0	7,906	5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	2,400	2,400	2,146	0	61,409,263
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	10,006	10,006	446,210	0	0
7.00 00700	OPERATION OF PLANT	5,493	5,493	0	0	0
8.00 00800	LAUNDRY & LINEN SERVICE	562	562	0	0	0
9.00 00900	HOUSEKEEPING	1,367	1,367	0	0	0
10.00 01000	DIETARY	3,191	3,191	0	0	0
11.00 01100	CAFETERIA	1,161	1,161	0	0	0
13.00 01300	NURSING ADMINISTRATION	266	266	308,558	0	0
14.00 01400	CENTRAL SERVICE & SUPPLY	865	865	0	0	0
15.00 01500	PHARMACY	1,222	1,222	253,610	194	0
16.00 01600	MEDICAL RECORDS & LIBRARY	1,813	1,813	0	0	0
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	9,475	9,475	1,287,345	4,064	3,987,350
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0
40.00 04000	SUBPROVIDER - IPF	6,747	6,747	1,062,025	3,095	4,122,749
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,964	5,964	368,086	89	4,958,442
51.00 05100	RECOVERY ROOM	0	0	0	0	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,576	4,576	652,437	146	20,135,989
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	2,387	2,387	118,577	9	10,171,074
65.00 06500	RESPIRATORY THERAPY	963	963	251,657	0	1,620,436
66.00 06600	PHYSICAL THERAPY	2,673	2,673	159,227	0	923,347
67.00 06700	OCCUPATIONAL THERAPY	1,577	1,577	89,662	0	681,068
68.00 06800	SPEECH PATHOLOGY	41	41	13,123	0	114,696
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	950,927
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	341,128
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,893,858
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	3,544	3,544	1,016,927	249	10,508,199
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	68,349	68,349	6,029,590	7,846	61,409,263
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	432	432	0	0	0
194.00 07950	OTHER NRCC - PHYSICIAN CLINIC	4,117	4,117	0	0	0
194.01 07951	OTHER NRCC - WIC	0	0	420,165	60	0
194.02 07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0
194.03 07953	OTHER NRCC - DR. OFFICE	2,629	2,629	0	0	0
194.04 07954	OTHER NRCC - MARKETING	0	0	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	39,215	31,419	1,840,815	17,810	21,187
203.00	Unit cost multiplier (Wkst. B, Part I)	0.519218	0.415997	0.285409	2.252719	0.000345
204.00	Cost to be allocated (per Wkst. B, Part II)			668	1,255	2,244
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000104	0.158740	0.000037
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: 15-1325

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

Worksheet B-1

Date/Time Prepared:
11/29/2022 10:58 am

Cost Center Description		Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (MINUTES OF SERVICE)	
		5A.04	5.04	7.00	8.00	9.00	
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
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	-7,187,996	14,357,987			5.04
7.00	00700	OPERATION OF PLANT	0	1,011,642	55,572		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	25,466	562	6,958	8.00
9.00	00900	HOUSEKEEPING	0	311,035	1,367	415	27,818
10.00	01000	DIETARY	0	276,365	3,191	0	0
11.00	01100	CAFETERIA	0	169,747	1,161	0	145
13.00	01300	NURSING ADMINISTRATION	0	484,580	266	0	0
14.00	01400	CENTRAL SERVICE & SUPPLY	0	809	865	0	0
15.00	01500	PHARMACY	0	286,786	1,222	0	480
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,695	1,813	0	30
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,740,933	9,475	1,860	9,395
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
40.00	04000	SUBPROVIDER - IPF	0	2,245,974	6,747	1,520	6,638
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	811,665	5,964	630	910
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,356,677	4,576	748	1,790
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	0	1,506,098	2,387	445	1,205
65.00	06500	RESPIRATORY THERAPY	0	344,549	963	44	292
66.00	06600	PHYSICAL THERAPY	0	208,008	2,673	198	570
67.00	06700	OCCUPATIONAL THERAPY	0	120,153	1,577	143	412
68.00	06800	SPEECH PATHOLOGY	0	17,275	41	15	42
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	162,860	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32,689	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	298,641	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	2,212,362	3,544	940	2,609
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-7,187,996	13,626,009	48,394	6,958	24,518
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	404	432	0	0
194.00	07950	OTHER NRCC - PHYSICIAN CLINIC	0	5,624	4,117	0	1,990
194.01	07951	OTHER NRCC - WIC	0	723,491	0	0	1,310
194.02	07952	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0
194.03	07953	OTHER NRCC - DR. OFFICE	0	2,459	2,629	0	0
194.04	07954	OTHER NRCC - MARKETING	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)		7,187,996	1,518,097	53,568	507,286
203.00		Unit cost multiplier (Wkst. B, Part I)		0.500627	27.317660	7.698764	18.235890
204.00		Cost to be allocated (per Wkst. B, Part II)		409,200	328,015	4,569	18,485
205.00		Unit cost multiplier (Wkst. B, Part II)		0.028500	5.902523	0.656654	0.664498
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: 15-1325

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

Worksheet B-1

Date/Time Prepared:
11/29/2022 10:58 am

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.02	00560						5.02
5.03	00580						5.03
5.04	00590						5.04
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	17,473					10.00
11.00	01100	0	145,552				11.00
13.00	01300	0	7,055	83,442			13.00
14.00	01400	0	0	0	100		14.00
15.00	01500	0	4,109	0	0	298,708	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	10,208	30,058	28,754	0	69	30.00
31.00	03100	0	0	0	0	0	31.00
40.00	04000	7,265	25,512	22,522	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	9,481	5,956	0	463	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	15,417	28	0	551	54.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	5,678	102	0	0	60.00
65.00	06500	0	6,699	722	0	0	65.00
66.00	06600	0	3,460	0	0	0	66.00
67.00	06700	0	2,162	0	0	0	67.00
68.00	06800	0	347	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	100	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	297,582	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	19,396	18,418	0	43	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		17,473	129,374	76,502	100	298,708	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	16,178	6,940	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00							201.00
202.00		501,892	289,087	748,452	24,844	480,655	202.00
203.00		28.723860	1.986142	8.969727	248.440000	1.609113	203.00
204.00		32,036	12,873	22,001	5,938	32,289	204.00
205.00		1.833457	0.088443	0.263668	59.380000	0.108096	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1325

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

Worksheet B-1
Date/Time Prepared:
11/29/2022 10:58 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100			1.00
2.00	00200			2.00
4.00	00400			4.00
5.02	00560			5.02
5.03	00580			5.03
5.04	00590			5.04
7.00	00700			7.00
8.00	00800			8.00
9.00	00900			9.00
10.00	01000			10.00
11.00	01100			11.00
13.00	01300			13.00
14.00	01400			14.00
15.00	01500			15.00
16.00	01600	61,409,263		16.00
17.00	01700	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	3,987,350	0	30.00
31.00	03100	0	0	31.00
40.00	04000	4,122,749	0	40.00
41.00	04100	0	0	41.00
42.00	04200	0	0	42.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	4,958,442	0	50.00
51.00	05100	0	0	51.00
52.00	05200	0	0	52.00
53.00	05300	0	0	53.00
54.00	05400	20,135,989	0	54.00
59.00	05900	0	0	59.00
60.00	06000	10,171,074	0	60.00
65.00	06500	1,620,436	0	65.00
66.00	06600	923,347	0	66.00
67.00	06700	681,068	0	67.00
68.00	06800	114,696	0	68.00
69.00	06900	0	0	69.00
71.00	07100	950,927	0	71.00
72.00	07200	341,128	0	72.00
73.00	07300	2,893,858	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	0	0	90.00
91.00	09100	10,508,199	0	91.00
92.00	09200			92.00
SPECIAL PURPOSE COST CENTERS				
118.00				118.00
SUBTOTALS (SUM OF LINES 1 through 117)		61,409,263	0	
NONREIMBURSABLE COST CENTERS				
190.00	19000	0	0	190.00
194.00	07950	0	0	194.00
194.01	07951	0	0	194.01
194.02	07952	0	0	194.02
194.03	07953	0	0	194.03
194.04	07954	0	0	194.04
200.00				200.00
201.00				201.00
202.00		52,618	0	202.00
203.00		0.000857	0.000000	203.00
204.00		12,464	0	204.00
205.00		0.000203	0.000000	205.00
206.00				206.00
207.00				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1325

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

Worksheet C
Part I
Date/Time Prepared:
11/29/2022 10:58 am

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		3,671,331	0	3,671,331	30.00
31.00	03100 INTENSIVE CARE UNIT		0	0	0	31.00
40.00	04000 SUBPROVIDER - I/PF		4,152,331	0	4,152,331	40.00
41.00	04100 SUBPROVIDER - I/RF		0	0	0	41.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		1,479,623	0	1,479,623	50.00
51.00	05100 RECOVERY ROOM		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,248,278	0	2,248,278	54.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		2,371,607	0	2,371,607	60.00
65.00	06500 RESPIRATORY THERAPY	0	570,181	0	570,181	65.00
66.00	06600 PHYSICAL THERAPY	0	404,743	0	404,743	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	236,877	0	236,877	67.00
68.00	06800 SPEECH PATHOLOGY	0	28,711	0	28,711	68.00
69.00	06900 ELECTROCARDIOLOGY		0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		270,051	0	270,051	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		49,346	0	49,346	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		929,472	0	929,472	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		0	0	0	90.00
91.00	09100 EMERGENCY		3,684,360	0	3,684,360	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		520,670	0	520,670	92.00
200.00	Subtotal (see instructions)	0	20,617,581	0	20,617,581	200.00
201.00	Less Observation Beds		520,670	0	520,670	201.00
202.00	Total (see instructions)	0	20,096,911	0	20,096,911	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1325

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

Worksheet C
Part I
Date/Time Prepared:
11/29/2022 10:58 am

		Title XVIII			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			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,449,960		2,449,960		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
40.00	04000	SUBPROVIDER - IPF	4,122,749		4,122,749		40.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	78,259	4,880,183	4,958,442	0.298405	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	377,070	19,758,919	20,135,989	0.111655	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	1,445,265	8,725,809	10,171,074	0.233172	60.00
65.00	06500	RESPIRATORY THERAPY	252,400	1,368,036	1,620,436	0.351869	65.00
66.00	06600	PHYSICAL THERAPY	544,262	379,085	923,347	0.438343	66.00
67.00	06700	OCCUPATIONAL THERAPY	561,207	119,861	681,068	0.347802	67.00
68.00	06800	SPEECH PATHOLOGY	89,880	24,816	114,696	0.250323	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	248,386	702,541	950,927	0.283987	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	198	340,930	341,128	0.144655	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,311,463	1,582,395	2,893,858	0.321188	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	155,567	10,352,632	10,508,199	0.350618	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	15,689	1,521,701	1,537,390	0.338671	92.00
200.00		Subtotal (see instructions)	11,652,355	49,756,908	61,409,263		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	11,652,355	49,756,908	61,409,263		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Prepared: 11/29/2022 10:58 am
		Title XVIII	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.298405		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.111655		54.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.233172		60.00
65.00	06500 RESPIRATORY THERAPY	0.351869		65.00
66.00	06600 PHYSICAL THERAPY	0.438343		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.347802		67.00
68.00	06800 SPEECH PATHOLOGY	0.250323		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.283987		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.144655		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.321188		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.350618		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.338671		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: 15-1325

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

Worksheet C
Part I
Date/Time Prepared:
11/29/2022 10:58 am

		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	3,671,331		3,671,331	0	3,671,331	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
40.00	04000 SUBPROVIDER - I/PF	4,152,331		4,152,331	0	4,152,331	40.00
41.00	04100 SUBPROVIDER - I/RF	0		0	0	0	41.00
42.00	04200 SUBPROVIDER	0		0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,479,623		1,479,623	0	1,479,623	50.00
51.00	05100 RECOVERY ROOM	0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,248,278		2,248,278	0	2,248,278	54.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000 LABORATORY	2,371,607		2,371,607	0	2,371,607	60.00
65.00	06500 RESPIRATORY THERAPY	570,181	0	570,181	0	570,181	65.00
66.00	06600 PHYSICAL THERAPY	404,743	0	404,743	0	404,743	66.00
67.00	06700 OCCUPATIONAL THERAPY	236,877	0	236,877	0	236,877	67.00
68.00	06800 SPEECH PATHOLOGY	28,711	0	28,711	0	28,711	68.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	270,051		270,051	0	270,051	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	49,346		49,346	0	49,346	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	929,472		929,472	0	929,472	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	3,684,360		3,684,360	0	3,684,360	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	520,670		520,670	0	520,670	92.00
200.00	Subtotal (see instructions)	20,617,581	0	20,617,581	0	20,617,581	200.00
201.00	Less Observation Beds	520,670		520,670	0	520,670	201.00
202.00	Total (see instructions)	20,096,911	0	20,096,911	0	20,096,911	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1325

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

Worksheet C
Part I
Date/Time Prepared:
11/29/2022 10:58 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			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,449,960		2,449,960		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
40.00	04000	SUBPROVIDER - IPF	4,122,749		4,122,749		40.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	78,259	4,880,183	4,958,442	0.298405	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	377,070	19,758,919	20,135,989	0.111655	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	1,445,265	8,725,809	10,171,074	0.233172	60.00
65.00	06500	RESPIRATORY THERAPY	252,400	1,368,036	1,620,436	0.351869	65.00
66.00	06600	PHYSICAL THERAPY	544,262	379,085	923,347	0.438343	66.00
67.00	06700	OCCUPATIONAL THERAPY	561,207	119,861	681,068	0.347802	67.00
68.00	06800	SPEECH PATHOLOGY	89,880	24,816	114,696	0.250323	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	248,386	702,541	950,927	0.283987	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	198	340,930	341,128	0.144655	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,311,463	1,582,395	2,893,858	0.321188	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	155,567	10,352,632	10,508,199	0.350618	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	15,689	1,521,701	1,537,390	0.338671	92.00
200.00		Subtotal (see instructions)	11,652,355	49,756,908	61,409,263		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	11,652,355	49,756,908	61,409,263		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Prepared: 11/29/2022 10:58 am
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
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
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
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
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 ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part II Date/Time Prepared: 11/29/2022 10:58 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)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	186,684	4,958,442	0.037650	9,367	353	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	440,152	20,135,989	0.021859	57,811	1,264	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	63,321	10,171,074	0.006226	78,637	490	60.00
65.00	06500 RESPIRATORY THERAPY	31,612	1,620,436	0.019508	24,230	473	65.00
66.00	06600 PHYSICAL THERAPY	28,971	923,347	0.031376	5,045	158	66.00
67.00	06700 OCCUPATIONAL THERAPY	14,938	681,068	0.021933	10,648	234	67.00
68.00	06800 SPEECH PATHOLOGY	869	114,696	0.007577	3,355	25	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10,808	950,927	0.011366	19,819	225	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,014	341,128	0.002972	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	41,372	2,893,858	0.014296	62,911	899	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	111,903	10,508,199	0.010649	14,558	155	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	22,910	1,537,390	0.014902	8,924	133	92.00
200.00	Total (lines 50 through 199)	954,554	54,836,554		295,305	4,409	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1325

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

Worksheet D
Part IV
Date/Time Prepared:
11/29/2022 10:58 am

Cost Center Description		Title XVIII				Hospital		
		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	Cost	
		1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
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: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Prepared: 11/29/2022 10:58 am
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Hospital		Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)		
				Total Charges (from Wkst. C, Part I, col. 8)	Cost			
	4.00	5.00	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	4,958,442	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	20,135,989	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	10,171,074	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,620,436	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	923,347	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	681,068	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	114,696	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	950,927	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	341,128	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,893,858	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	10,508,199	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,537,390	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	54,836,554		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1325

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

Worksheet D
Part IV
Date/Time Prepared:
11/29/2022 10:58 am

Cost Center Description		Title XVIII			Hospital		Cost	
		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	9,367	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	57,811	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	78,637	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	24,230	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	5,045	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	10,648	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	3,355	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	19,819	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	62,911	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	14,558	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	8,924	0	0	0	92.00
200.00		Total (lines 50 through 199)		295,305	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Prepared: 11/29/2022 10:58 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.)			
		1.00	2.00	3.00			
			4.00	5.00			
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.298405	0	1,353,820	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.111655	0	5,105,640	0	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.233172	0	1,924,955	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.351869	0	484,387	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.438343	0	153,620	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.347802	0	25,988	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.250323	0	4,446	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.283987	0	152,905	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.144655	0	162,463	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.321188	0	381,632	1,168	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.350618	0	1,798,040	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.338671	0	142,458	0	0	92.00
200.00	Subtotal (see instructions)		0	11,690,354	1,168	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	11,690,354	1,168	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Prepared: 11/29/2022 10:58 am
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	403,987	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	570,070	0		54.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	448,846	0		60.00
65.00 06500 RESPIRATORY THERAPY	170,441	0		65.00
66.00 06600 PHYSICAL THERAPY	67,338	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	9,039	0		67.00
68.00 06800 SPEECH PATHOLOGY	1,113	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	43,423	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	23,501	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	122,576	375		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	630,425	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	48,246	0		92.00
200.00 Subtotal (see instructions)	2,539,005	375		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	2,539,005	375		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 15-1325 Component CCN: 15-M325		Period: From 07/01/2021 To 06/30/2022		Worksheet D Part II Date/Time Prepared: 11/29/2022 10:58 am	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	186,684	4,958,442	0.037650	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	440,152	20,135,989	0.021859	56,631	1,238	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	63,321	10,171,074	0.006226	443,028	2,758	60.00
65.00	06500	RESPIRATORY THERAPY	31,612	1,620,436	0.019508	10,234	200	65.00
66.00	06600	PHYSICAL THERAPY	28,971	923,347	0.031376	1,944	61	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,938	681,068	0.021933	1,052	23	67.00
68.00	06800	SPEECH PATHOLOGY	869	114,696	0.007577	7,766	59	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,808	950,927	0.011366	12,320	140	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,014	341,128	0.002972	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,372	2,893,858	0.014296	319,058	4,561	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	111,903	10,508,199	0.010649	3,737	40	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,537,390	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	931,644	54,836,554		855,770	9,080	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1325 Component CCN: 15-M325	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Prepared: 11/29/2022 10:58 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
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
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
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
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: 15-1325 Component CCN: 15-M325	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Prepared: 11/29/2022 10:58 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description			All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	4,958,442	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	20,135,989	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	10,171,074	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,620,436	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	923,347	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	681,068	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	114,696	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	950,927	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	341,128	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,893,858	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	10,508,199	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,537,390	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	54,836,554		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-1325 Component CCN: 15-M325		Period: From 07/01/2021 To 06/30/2022		Worksheet D Part IV Date/Time Prepared: 11/29/2022 10:58 am	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	56,631	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	443,028	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	10,234	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,944	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,052	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	7,766	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	12,320	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	319,058	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	3,737	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		855,770	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1325 Component CCN: 15-M325	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Prepared: 11/29/2022 10:58 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.298405	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.111655	0	0	0	0	54.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00 06000 LABORATORY	0.233172	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.351869	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.438343	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.347802	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.250323	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.283987	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.144655	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.321188	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.000000	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.350618	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.338671	0	0	0	0	92.00
200.00 Subtotal (see instructions)		0	0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00 Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1325 Component CCN: 15-M325	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Prepared: 11/29/2022 10:58 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
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
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	0	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
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	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1325 Component CCN: 15-Z325	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Prepared: 11/29/2022 10:58 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.298405	0	0	0	0
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.111655	0	0	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.233172	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.351869	0	0	0	0
66.00 06600 PHYSICAL THERAPY	0.438343	0	0	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.347802	0	0	0	0
68.00 06800 SPEECH PATHOLOGY	0.250323	0	0	0	0
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.283987	0	0	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.144655	0	0	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.321188	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0.000000	0	0	0	0
91.00 09100 EMERGENCY	0.350618	0	0	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.338671	0	0	0	0
200.00 Subtotal (see instructions)		0	0	0	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00 Net Charges (line 200 - line 201)			0	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1325 Component CCN: 15-Z325	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Prepared: 11/29/2022 10:58 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
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
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	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
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	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part III Date/Time Prepared: 11/29/2022 10:58 am
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Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	624	0.00	3	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0.00	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	1,962	0.00	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00	
200.00		Total (lines 30 through 199)	0	0	2,586		3	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
40.00	04000	SUBPROVIDER - IPF	0						40.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
42.00	04200	SUBPROVIDER	0						42.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1325

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

Worksheet D
Part IV
Date/Time Prepared:
11/29/2022 10:58 am

Cost Center Description		Title XIX			Hospital		
		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
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
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1325

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

Worksheet D
Part IV
Date/Time Prepared:
11/29/2022 10:58 am

Cost Center Description			Title XIX		Hospital		Cost	
			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	4,958,442	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	20,135,989	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	10,171,074	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,620,436	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	923,347	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	681,068	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	114,696	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	950,927	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	341,128	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,893,858	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	10,508,199	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,537,390	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	54,836,554		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1325

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

Worksheet D
Part IV
Date/Time Prepared:
11/29/2022 10:58 am

Cost Center Description			Title XIX			Hospital		Cost
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	5,600	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	5,891	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,102	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	7,240	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		19,833	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Prepared: 11/29/2022 10:58 am
Title XIX		Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.298405	0	8,159	0	0
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.111655	0	179,401	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.233172	0	130,890	0	0
65.00 06500 RESPIRATORY THERAPY	0.351869	0	2,346	0	0
66.00 06600 PHYSICAL THERAPY	0.438343	0	1,031	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.347802	0	0	0	0
68.00 06800 SPEECH PATHOLOGY	0.250323	0	0	0	0
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.283987	0	0	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.144655	0	0	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.321188	0	9,701	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0.000000	0	0	0	0
91.00 09100 EMERGENCY	0.350618	0	216,288	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.338671	0	12,985	0	0
200.00 Subtotal (see instructions)		0	560,801	0	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00 Net Charges (line 200 - line 201)		0	560,801	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Prepared: 11/29/2022 10:58 am
	Title XIX	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	2,435	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	20,031	0		54.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	30,520	0		60.00
65.00 06500 RESPIRATORY THERAPY	825	0		65.00
66.00 06600 PHYSICAL THERAPY	452	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
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	3,116	0		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	75,834	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,398	0		92.00
200.00 Subtotal (see instructions)	137,611	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	137,611	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepared: 11/29/2022 10:58 am
Cost Center Description		Title XVIII	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)		2,686	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		624	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)		273	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		906	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)		906	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		125	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)		125	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		135	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)		355	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)		354	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			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		231.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		231.10	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,671,331	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)		28,888	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)		28,888	25.00
26.00	Total swing-bed cost (see instructions)		2,745,697	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		925,634	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)		925,634	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)		1,483.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		200,259	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)		200,259	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepared: 11/29/2022 10:58 am		
Cost Center Description			Title XVIII		Hospital		
Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
			1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT			0	0	0.00	0
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						76,826
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						277,085
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0
52.00	Total Program excludable cost (sum of lines 50 and 51)						0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						0
55.00	Target amount per discharge						0.00
56.00	Target amount (line 54 x line 55)						0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0
58.00	Bonus payment (see instructions)						0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0
62.00	Relief payment (see instructions)						0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						526,607
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						525,124
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						1,051,731
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						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)						351
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,483.39
89.00	Observation bed cost (line 87 x line 88) (see instructions)						520,670

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1325		Period: From 07/01/2021 To 06/30/2022		Worksheet D-1 Date/Time Prepared: 11/29/2022 10:58 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	161,542	3,671,331	0.044001	520,670	22,910	90.00
91.00	Nursing Program cost	0	3,671,331	0.000000	520,670	0	91.00
92.00	Allied health cost	0	3,671,331	0.000000	520,670	0	92.00
93.00	All other Medical Education	0	3,671,331	0.000000	520,670	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1325 Component CCN: 15-M325	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepared: 11/29/2022 10:58 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,962	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,962	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,962	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,747	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			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		231.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		231.10	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,152,331	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,152,331	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,152,331	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)		2,116.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,697,316	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)		3,697,316	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1325 Component CCN: 15-M325		Period: From 07/01/2021 To 06/30/2022		Worksheet D-1 Date/Time Prepared: 11/29/2022 10:58 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					223,675	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,920,991	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)					9,080	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					9,080	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,911,911	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1325 Component CCN: 15-M325		Period: From 07/01/2021 To 06/30/2022		Worksheet D-1 Date/Time Prepared: 11/29/2022 10:58 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	4,152,331	0.000000	0	0	90.00
91.00	Nursing Program cost	0	4,152,331	0.000000	0	0	91.00
92.00	Allied health cost	0	4,152,331	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,152,331	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepared: 11/29/2022 10:58 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)		2,686	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		624	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)		273	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		906	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)		906	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		250	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	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			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		231.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		231.10	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,671,331	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)		57,775	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)		2,745,696	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		925,635	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)		925,635	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)		1,483.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,450	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)		4,450	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepared: 11/29/2022 10:58 am
Cost Center Description			Title XIX		Hospital
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	0	0	0.00	0	0
44.00					
45.00					
46.00					
47.00					
Cost Center Description					
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				4,891
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				9,341
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				0
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0
52.00	Total Program excludable cost (sum of lines 50 and 51)				0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0
55.00	Target amount per discharge				0.00
56.00	Target amount (line 54 x line 55)				0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0
58.00	Bonus payment (see instructions)				0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0
62.00	Relief payment (see instructions)				0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)				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)				351
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,483.39
89.00	Observation bed cost (line 87 x line 88) (see instructions)				520,670

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1325		Period: From 07/01/2021 To 06/30/2022		Worksheet D-1 Date/Time Prepared: 11/29/2022 10:58 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	161,542	3,671,331	0.044001	520,670	22,910	90.00
91.00	Nursing Program cost	0	3,671,331	0.000000	520,670	0	91.00
92.00	Allied health cost	0	3,671,331	0.000000	520,670	0	92.00
93.00	All other Medical Education	0	3,671,331	0.000000	520,670	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet D-3 Date/Time Prepared: 11/29/2022 10:58 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		159,835	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.298405	9,367	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111655	57,811	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.233172	78,637	60.00
65.00	06500	RESPIRATORY THERAPY	0.351869	24,230	65.00
66.00	06600	PHYSICAL THERAPY	0.438343	5,045	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347802	10,648	67.00
68.00	06800	SPEECH PATHOLOGY	0.250323	3,355	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.283987	19,819	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.144655	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321188	62,911	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.350618	14,558	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.338671	8,924	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		295,305	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)		295,305	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1325 Component CCN: 15-M325	Period: From 07/01/2021 To 06/30/2022	Worksheet D-3 Date/Time Prepared: 11/29/2022 10:58 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF		3,659,600	40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.298405	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111655	56,631	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.233172	443,028	60.00
65.00	06500	RESPIRATORY THERAPY	0.351869	10,234	65.00
66.00	06600	PHYSICAL THERAPY	0.438343	1,944	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347802	1,052	67.00
68.00	06800	SPEECH PATHOLOGY	0.250323	7,766	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.283987	12,320	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.144655	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321188	319,058	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.350618	3,737	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.338671	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			855,770	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)			855,770	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1325 Component CCN: 15-Z325	Period: From 07/01/2021 To 06/30/2022	Worksheet D-3 Date/Time Prepared: 11/29/2022 10:58 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			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.298405	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111655	42,100	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.233172	221,673	60.00
65.00	06500	RESPIRATORY THERAPY	0.351869	27,454	65.00
66.00	06600	PHYSICAL THERAPY	0.438343	189,401	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347802	206,925	67.00
68.00	06800	SPEECH PATHOLOGY	0.250323	27,560	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.283987	59,233	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.144655	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321188	265,436	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.350618	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.338671	6,765	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,046,547	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		1,046,547	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet D-3 Date/Time Prepared: 11/29/2022 10:58 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		3,569	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.298405	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111655	5,600	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.233172	5,891	60.00
65.00	06500	RESPIRATORY THERAPY	0.351869	0	65.00
66.00	06600	PHYSICAL THERAPY	0.438343	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347802	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.250323	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.283987	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.144655	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321188	1,102	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.350618	7,240	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.338671	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		19,833	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)		19,833	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1325 Component CCN: 15-M325	Period: From 07/01/2021 To 06/30/2022	Worksheet D-3 Date/Time Prepared: 11/29/2022 10:58 am
		Title XIX	Subprovider - IPF	Cost
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF		41.00
42.00	04200	SUBPROVIDER		42.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.298405	0 50.00
51.00	05100	RECOVERY ROOM	0.000000	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111655	0 54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0 59.00
60.00	06000	LABORATORY	0.233172	0 60.00
65.00	06500	RESPIRATORY THERAPY	0.351869	0 65.00
66.00	06600	PHYSICAL THERAPY	0.438343	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347802	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.250323	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.283987	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.144655	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321188	0 73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0 90.00
91.00	09100	EMERGENCY	0.350618	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.338671	0 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0 201.00
202.00		Net charges (line 200 minus line 201)		0 202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part B Date/Time Prepared: 11/29/2022 10:58 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			2,539,380 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	OPPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			2,539,380 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			2,564,774 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)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			24,062 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			1,919,220 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)			621,492 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)			621,492 30.00
31.00	Primary payer payments			872 31.00
32.00	Subtotal (line 30 minus line 31)			620,620 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)			173,504 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			112,778 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			104,496 36.00
37.00	Subtotal (see instructions)			733,398 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)			733,398 40.00
40.01	Sequestration adjustment (see instructions)			1,833 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			893,421 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)			-161,856 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			25,000 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part B Date/Time Prepared: 11/29/2022 10:58 am
Title XVIII		Hospital	Cost
			1.00
200.00	MEDI CARE PART B ANCI LLARY COSTS Part B Combined Billed Days		0 200.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1325 Component CCN: 15-M325	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part B Date/Time Prepared: 11/29/2022 10:58 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		0	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)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		0	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		0	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		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: 15-1325 Component CCN: 15-M325	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part B Date/Time Prepared: 11/29/2022 10:58 am
	Title XVIII	Subprovider - IPF	PPS
			1.00
200.00	MEDI CARE PART B ANCILLARY COSTS Part B Combined Billed Days		
			200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1325

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

Worksheet E-1
Part I
Date/Time Prepared:
11/29/2022 10:58 am

		Title XVIII		Hospital		Cost	
		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		163,575		893,421	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)		163,575		893,421	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		72,823		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		161,856	6.02	
7.00	Total Medicare program liability (see instructions)		236,398		731,565	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-1325 Component CCN: 15-M325	Period: From 07/01/2021 To 06/30/2022	Worksheet E-1 Part I Date/Time Prepared: 11/29/2022 10:58 am	
		Title XVIII	Subprovider - IPF	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				0
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,717,239		0
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				0
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,717,239		0
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				0
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				0
6.01	SETTLEMENT TO PROVIDER		14,437		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		1,731,676		0
				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				0

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1325
Component CCN: 15-Z325

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

Worksheet E-1
Part I
Date/Time Prepared:
11/29/2022 10:58 am

		Title XVIII		Swing Beds - SNF		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,074,697		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	03/02/2022	92,900		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)		92,900		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,167,597		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		215,899		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,383,496		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet E-1 Part II Date/Time Prepared: 11/29/2022 10:58 am
		Title XVIII	Hospital	Cost
				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 - SWING BEDS		Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet E-2
		Component CCN: 15-Z325		Date/Time Prepared: 11/29/2022 10:58 am
		Title XVIII	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,062,248	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	335,630	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	709	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,397,878	0	8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	1,397,878	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,397,878	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	14,242	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,383,636	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	5,118		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	3,327		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	928		18.00
19.00	Total (see instructions)	1,386,963	0	19.00
19.01	Sequestration adjustment (see instructions)	3,467	0	19.01
19.02	Demonstration payment adjustment amount after sequestration	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	1,167,597	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	215,899	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part V Date/Time Prepared: 11/29/2022 10:58 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			277,085 1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			277,085 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			279,856 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	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 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			279,856 19.00
20.00	Deductibles (exclude professional component)			46,724 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			233,132 22.00
23.00	Coinurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			233,132 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			5,936 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			3,858 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			4,452 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			236,990 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.98	Recovery of accelerated depreciation.			0 29.98
29.99	Demonstration payment adjustment amount before sequestration			0 29.99
30.00	Subtotal (see instructions)			236,990 30.00
30.01	Sequestration adjustment (see instructions)			592 30.01
30.02	Demonstration payment adjustment amount after sequestration			0 30.02
30.03	Sequestration adjustment-PARHM			0 30.03
31.00	Interim payments			163,575 31.00
31.01	Interim payments-PARHM			0 31.01
32.00	Tentative settlement (for contractor use only)			0 32.00
32.01	Tentative settlement-PARHM (for contractor use only)			0 32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)			72,823 33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)			0 33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			25,000 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1325 Component CCN: 15-M325	Period: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part II Date/Time Prepared: 11/29/2022 10:58 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			1,741,369 1.00
2.00	Net IPF PPS Outlier Payments			91,387 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			5.375342 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1,832,756 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			1,832,756 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,832,756 18.00
19.00	Deductibles			106,328 19.00
20.00	Subtotal (line 18 minus line 19)			1,726,428 20.00
21.00	Coinsurance			4,081 21.00
22.00	Subtotal (line 20 minus line 21)			1,722,347 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			21,029 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			13,669 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			10,989 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,736,016 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.98	Recovery of accelerated depreciation.			0 30.98
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			1,736,016 31.00
31.01	Sequestration adjustment (see instructions)			4,340 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			1,717,239 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			14,437 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			91,387 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.			0.000000 99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)			0.000000 99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1325	Period: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part VII Date/Time Prepared: 11/29/2022 10:58 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		9,341		1.00
2.00	Medical and other services			137,611	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		9,341	137,611	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		9,341	137,611	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		3,569		8.00
9.00	Ancillary service charges		19,833	560,801	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)		23,402	560,801	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)		23,402	560,801	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		14,061	423,190	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		9,341	137,611	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)		9,341	137,611	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		9,341	137,611	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)		9,341	137,611	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		9,341	137,611	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)		9,341	137,611	40.00
41.00	Interim payments		9,341	137,611	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: 15-1325

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

Worksheet G

Date/Time Prepared: 11/29/2022 10:58 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	434,835	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	7,999,745	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,184,926	0	0	0	6.00
7.00	Inventory	230,049	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,479,703	0	0	0	11.00
FIXED ASSETS						
12.00	Land	808,762	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	14,381,172	0	0	0	15.00
16.00	Accumulated depreciation	-10,777,736	0	0	0	16.00
17.00	Leasehold improvements	164,374	0	0	0	17.00
18.00	Accumulated depreciation	-97,877	0	0	0	18.00
19.00	Fixed equipment	10,551,278	0	0	0	19.00
20.00	Accumulated depreciation	-9,080,295	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	5,949,678	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	9,429,381	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	284,770	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	39,038	0	0	0	39.00
40.00	Notes and loans payable (short term)	122,331	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	10,337,151	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,783,290	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	66,497	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	66,497	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	10,849,787	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-1,420,406				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-1,420,406	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	9,429,381	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1325

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

Worksheet G-1

Date/Time Prepared:
11/29/2022 10:58 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-1,974,580		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-729,823				2.00
3.00	Total (sum of line 1 and line 2)		-2,704,403		0		3.00
4.00	Transfer to/from affiliates	1,283,997		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		1,283,997		0		10.00
11.00	Subtotal (line 3 plus line 10)		-1,420,406		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00	Rounding	0		0		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)		-1,420,406		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Transfer to/from affiliates		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			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: 15-1325

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/29/2022 10:58 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,453,103		2,453,103	1.00
2.00	SUBPROVIDER - IPF	4,122,749		4,122,749	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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)	6,575,852		6,575,852	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,575,852		6,575,852	17.00
18.00	Ancillary services	4,915,279	37,848,964	42,764,243	18.00
19.00	Outpatient services	155,567	11,928,786	12,084,353	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	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,646,698	49,777,750	61,424,448	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		21,449,960		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)		21,449,960		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-1325

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

Worksheet G-3

Date/Time Prepared:
11/29/2022 10:58 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	61,424,448	1.00
2.00	Less contractual allowances and discounts on patients' accounts	41,663,962	2.00
3.00	Net patient revenues (line 1 minus line 2)	19,760,486	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	21,449,960	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,689,474	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	50,387	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	40,363	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	50	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	34	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	Other Operating Revenue	547,785	24.00
24.01	Exercise Revenue	3,900	24.01
24.06	Building Rent	13,047	24.06
24.11	Physician Clinic	87,218	24.11
24.50	COVID-19 PHE Funding	216,867	24.50
25.00	Total other income (sum of lines 6-24)	959,651	25.00
26.00	Total (line 5 plus line 25)	-729,823	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)	-729,823	29.00