

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

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/18/2023 11:36 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 5/18/2023	Time: 11:36 am
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HUNTINGTON MEMORIAL HOSPITAL (15-0091) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	226,810	33,028	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	2.00
3.00	SUBPROVIDER - IRF	0	0	0	0	3.00
5.00	SWING BED - SNF	0	0	0	0	5.00
6.00	SWING BED - NF	0	0	0	0	6.00
200.00	TOTAL	0	226,810	33,028	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDI-CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0091		Period: From 01/01/2022 To 12/31/2022		Worksheet S-2 Part I Date/Time Prepared: 5/18/2023 11:36 am				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 2001 STULTS ROAD	PO Box:							1.00	
2.00	City: HUNTINGTON	State: IN		Zip Code: 46750		County: HUNTINGTON			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	HUNTINGTON MEMORIAL HOSPITAL	150091	99915	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2022	12/31/2022		20.00	
21.00	Type of Control (see instructions)					2			21.00	
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				Y	N			22.00	
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	N			22.01	
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 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.								22.04	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				3	N			23.00	

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		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.	143	52	0	0	1,074	79		24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	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.					2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					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)					Y	Y		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					Y	N		40.00
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you 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	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.					N			57.00

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		V	XVIII	XIX		
		1.00	2.00	3.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	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
61.01	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 baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).					61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)					61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)					61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20
						1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N	63.00

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			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
			1.00	2.00	3.00	
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.					64.00
Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	
		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)					65.00
			0.00	0.00	0.000000	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					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	
		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)					67.00
			0.00	0.00	0.000000	

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			1.00		
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?		N		68.00
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		N		70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)		0		71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		N		75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)		0		76.00
			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
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
			1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.				0 88.00
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge
			1.00	2.00	3.00
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.		0.00		0 89.00
			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

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		V 1.00	XIX 2.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. 1, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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. 1V, 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. 1, 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. 1 through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			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)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N			109.00
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00
				1.00	2.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.		N		111.00
				1.00	2.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
113.00	Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.				113.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	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.		1		118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/18/2023 11:36 am	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	88,672	943	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N	118.02	
119.00	DO NOT USE THIS LINE			119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		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.		N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.				123.00
Certified Transplant Center Information					
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	Removed and reserved				133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	15H032	140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: PARKVIEW HEALTH SYSTEM, INC.	Contractor's Name: WISCONSIN PHYSICIANS SERVICE		Contractor's Number: 08101	141.00
142.00	Street: 10501 CORPORATE DRIVE	PO Box: 5600			142.00
143.00	City: FORT WAYNE	State: IN	Zip Code: 46895-5600		143.00
			1.00		
144.00	Are provider based physicians' costs included in Worksheet A?		Y		144.00
			1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0091		Period: From 01/01/2022 To 12/31/2022		Worksheet S-2 Part I Date/Time Prepared: 5/18/2023 11:36 am													
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											
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 25%;">Part A</th> <th style="width: 25%;">Part B</th> <th style="width: 25%;">Title V</th> <th style="width: 25%;">Title XIX</th> </tr> <tr> <td style="text-align: center;">1.00</td> <td style="text-align: center;">2.00</td> <td style="text-align: center;">3.00</td> <td style="text-align: center;">4.00</td> </tr> </table>								Part A	Part B	Title V	Title XIX	1.00	2.00	3.00	4.00				
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	N	155.00												
156.00	Subprovider - IPF	N	N	N	N	N	156.00												
157.00	Subprovider - IRF	N	N	N	N	N	157.00												
158.00	SUBPROVIDER	N	N	N	N	N	158.00												
159.00	SNF	N	N	N	N	N	159.00												
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00												
161.00	CMHC	N	N	N	N	N	161.00												
1.00																			
165.00	Multi campus 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											
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name</th> <th style="width: 15%;">County</th> <th style="width: 10%;">State</th> <th style="width: 10%;">Zip Code</th> <th style="width: 10%;">CBSA</th> <th style="width: 10%;">FTE/Campus</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">0</td> <td style="text-align: center;">1.00</td> <td style="text-align: center;">2.00</td> <td style="text-align: center;">3.00</td> <td style="text-align: center;">4.00</td> <td style="text-align: center;">5.00</td> </tr> </tbody> </table>								Name	County	State	Zip Code	CBSA	FTE/Campus	0	1.00	2.00	3.00	4.00	5.00
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)							168.01											
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						9.99	169.00											
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">Beginning</th> <th style="width: 50%;">Ending</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1.00</td> <td style="text-align: center;">2.00</td> </tr> </tbody> </table>								Beginning	Ending	1.00	2.00								
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											
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">Beginning</th> <th style="width: 50%;">Ending</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1.00</td> <td style="text-align: center;">2.00</td> </tr> </tbody> </table>								Beginning	Ending	1.00	2.00								
Beginning	Ending																		
1.00	2.00																		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	171.00											

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/18/2023 11:36 am		
			Y/N	Date		
			1.00	2.00		
PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE						
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.						
COMPLETED BY ALL HOSPITALS						
Provider Organization and Operation						
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00	
			Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00	
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			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	03/17/2021	4.00	
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00	
			Y/N	Legal Oper.		
			1.00	2.00		
Approved Educational Activities						
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N			6.00	
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	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 coinsurance amounts waived? If yes, see instructions.			N	14.00	
Bed Complement						
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00	
			Part A		Part B	
			Y/N	Date	Y/N	Date
			1.00	2.00	3.00	4.00
PS&R Data						
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/30/2021	Y	04/30/2021	
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.	Y		Y		
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: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/18/2023 11:36 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				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SHANNON		ECENBARGER	41.00
42.00	Enter the employer/company name of the cost report preparer.	PARKVIEW HEALTH SYSTEM, INC.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(260) 373-8457		SHANNON.ECENBARGER@PARKVIEW.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/18/2023 11:36 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.	DIRECTOR, REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0091

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

Worksheet S-3
Part I
Date/Time Prepared:
5/18/2023 11:36 am

Component	Worksheet A Line No.	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps		
					Title V		
	1.00	2.00	3.00	4.00	5.00		
PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	36	13,140	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		36	13,140	0.00	0	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	43.00				0	13.00
14.00	Total (see instructions)		36	13,140	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		36				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0091

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

Worksheet S-3
Part I
Date/Time Prepared:
5/18/2023 11:36 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	982	118	4,182		1.00
2.00	HMO and other (see instructions)	1,496	1,126			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0	0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	982	118	4,182		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		25	605		13.00
14.00	Total (see instructions)	982	143	4,787	0.00	14.00
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			71		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
27.00	Total (sum of lines 14-26)				0.00	225.13
28.00	Observation Bed Days		30	1,872		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	79	122		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0		34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0091

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

Worksheet S-3
Part I
Date/Time Prepared:
5/18/2023 11:36 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
PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	296	37	1,514	1.00
2.00	HMO and other (see instructions)			469	350		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	296	37	1,514	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0091

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

Worksheet S-3
Part II
Date/Time Prepared:
5/18/2023 11:36 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	18,644,780	4,465,626	23,110,406	594,204.33	38.89 1.00
2.00	Non-physician anesthesiologist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthesiologist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		4,465,626	0	4,465,626	97,108.94	45.99 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		3,238,411	202,894	3,441,305	125,484.75	27.42 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		0	0	0	0.00	0.00 11.00
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		4,465,626	0	4,465,626	97,108.94	45.99 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00 16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.02
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		5,163,433	0	5,163,433		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,390,756	0	1,390,756		
20.00	Non-physician anesthesiologist Part A		0	0	0		
21.00	Non-physician anesthesiologist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		1,501,965	0	1,501,965		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0091

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

Worksheet S-3
Part II
Date/Time Prepared:
5/18/2023 11:36 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	1,757,788	-1,757,788	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	1,295,027	4,553,500	5,848,527	107,400.52	54.46	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	391,034	43,144	434,178	13,301.26	32.64	30.00
31.00	Laundry & Linen Service	8.00	0	52,509	52,509	2,352.00	22.33	31.00
32.00	Housekeeping	9.00	447,464	-3,139	444,325	21,170.31	20.99	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	607,305	-263,992	343,313	14,260.28	24.07	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	330,998	330,998	14,113.00	23.45	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	378,649	41,777	420,426	8,574.00	49.03	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	609,910	0	609,910	10,885.00	56.03	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0091

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

Worksheet S-3
Part III
Date/Time Prepared:
5/18/2023 11:36 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	14,179,154	4,465,626	18,644,780	497,095.39	37.51	1.00
2.00	Excluded area salaries (see instructions)	3,238,411	202,894	3,441,305	125,484.75	27.42	2.00
3.00	Subtotal salaries (line 1 minus line 2)	10,940,743	4,262,732	15,203,475	371,610.64	40.91	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,465,626	0	4,465,626	97,108.94	45.99	4.00
5.00	Subtotal wage-related costs (see inst.)	6,665,398	0	6,665,398	0.00	43.84	5.00
6.00	Total (sum of lines 3 thru 5)	22,071,767	4,262,732	26,334,499	468,719.58	56.18	6.00
7.00	Total overhead cost (see instructions)	5,487,177	2,997,009	8,484,186	192,056.37	44.18	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part IV Date/Time Prepared: 5/18/2023 11:36 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	396,788	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1,227,687	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	2,896	6.00
7.00	Employee Managed Care Program Administration Fees	61,709	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	2,517,325	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	686,464	9.00
10.00	Dental, Hearing and Vision Plan	79,487	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	15,448	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	61,083	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	9,128	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	1,423,582	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	49,449	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	23,143	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,554,189	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part V Date/Time Prepared: 5/18/2023 11:36 am
Cost Center Description			Contract Labor	Benefit Cost
PART V - Contract Labor and Benefit Cost			1.00	2.00
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0 1.00
2.00	Hospital		0	0 2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other		0	0 18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet S-10 Date/Time Prepared: 5/18/2023 11:36 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)			0.209083	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			5,179,923	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			Y	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			28,994,309	6.00	
7.00	Medicaid cost (line 1 times line 6)			6,062,217	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)			882,294	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone CHIP			20,150	9.00	
10.00	Stand-alone CHIP charges			71,927	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)			15,039	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)			6,584,055	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			32,757,897	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			6,849,119	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)			265,064	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)			1,147,358	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)	3,109,213	1,078,690	4,187,903	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	650,084	1,078,690	1,728,774	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)	650,084	1,078,690	1,728,774	23.00	
				1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)			3,709,841	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			41,698	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			64,150	27.01	
28.00	Non-Medicare bad debt expense (see instructions)			3,645,691	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			784,704	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			2,513,478	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			3,660,836	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0091

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

Worksheet A
Date/Time Prepared:
5/18/2023 11:36 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,010,421	2,010,421	52,911	2,063,332	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,093,215	1,093,215	46,361	1,139,576	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,757,788	6,258,695	8,016,483	-1,757,788	6,258,695	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,295,027	23,267,391	24,562,418	-11,398	24,551,020	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	391,034	865,488	1,256,522	43,144	1,299,666	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	145,274	145,274	52,509	197,783	8.00
9.00	00900	HOUSEKEEPING	447,464	145,207	592,671	-3,139	589,532	9.00
10.00	01000	DIETARY	607,305	423,056	1,030,361	-507,529	522,832	10.00
11.00	01100	CAFETERIA	0	0	0	574,535	574,535	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	378,649	6,914	385,563	41,777	427,340	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	609,910	154,685	764,595	0	764,595	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,726,630	1,261,514	4,988,144	-599,307	4,388,837	30.00
43.00	04300	NURSERY	0	0	0	185,705	185,705	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,257,318	617,799	1,875,117	138,723	2,013,840	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	928,790	928,790	52.00
53.00	05300	ANESTHESIOLOGY	0	1,253,037	1,253,037	0	1,253,037	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,217,360	599,078	1,816,438	134,315	1,950,753	54.00
60.00	06000	LABORATORY	266	2,895,484	2,895,750	29	2,895,779	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	677,093	148,187	825,280	74,705	899,985	65.00
66.00	06600	PHYSICAL THERAPY	1,205,339	51,027	1,256,366	-335,614	920,752	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	257,005	257,005	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	211,597	211,597	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,439,202	1,439,202	-883,584	555,618	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	883,584	883,584	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,060,989	2,060,989	67,293	2,128,282	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	262,014	453,231	715,245	28,909	744,154	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	138,777	16,521	155,298	15,312	170,610	90.00
91.00	09100	EMERGENCY	1,434,395	249,956	1,684,351	158,261	1,842,612	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	3,154,133	655,670	3,809,803	193,596	4,003,399	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,560,502	46,072,041	64,632,543	-9,298	64,623,245	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,768	23,768	0	23,768	190.00
191.00	19100	RESEARCH	0	637	637	0	637	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	74,668	9,832	84,500	8,238	92,738	192.00
194.00	07950	OCC HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	69,145	69,145	0	69,145	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	9,610	67,427	77,037	1,060	78,097	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	18,644,780	46,242,850	64,887,630	0	64,887,630	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0091

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

Worksheet A
Date/Time Prepared:
5/18/2023 11:36 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	615,062	2,678,394	1.00
2.00	00200	644,763	1,784,339	2.00
3.00	00300	0	0	3.00
4.00	00400	-3,208	6,255,487	4.00
5.00	00500	-10,429,303	14,121,717	5.00
6.00	00600	0	0	6.00
7.00	00700	-2,326	1,297,340	7.00
8.00	00800	0	197,783	8.00
9.00	00900	0	589,532	9.00
10.00	01000	-4,529	518,303	10.00
11.00	01100	-418,418	156,117	11.00
12.00	01200	0	0	12.00
13.00	01300	0	427,340	13.00
14.00	01400	0	0	14.00
15.00	01500	-55,897	708,698	15.00
16.00	01600	0	0	16.00
17.00	01700	0	0	17.00
19.00	01900	0	0	19.00
20.00	02000	0	0	20.00
21.00	02100	0	0	21.00
22.00	02200	0	0	22.00
23.00	02300	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	26,632	4,415,469	30.00
43.00	04300	0	185,705	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	-1,253,037	760,803	50.00
50.01	05001	0	0	50.01
52.00	05200	0	928,790	52.00
53.00	05300	0	1,253,037	53.00
54.00	05400	-487	1,950,266	54.00
60.00	06000	0	2,895,779	60.00
62.30	06250	0	0	62.30
65.00	06500	0	899,985	65.00
66.00	06600	-23,023	897,729	66.00
67.00	06700	0	257,005	67.00
68.00	06800	0	211,597	68.00
69.00	06900	0	0	69.00
71.00	07100	0	555,618	71.00
72.00	07200	0	883,584	72.00
73.00	07300	0	2,128,282	73.00
76.97	07697	0	0	76.97
76.98	07698	0	744,154	76.98
76.99	07699	0	0	76.99
77.00	07700	0	0	77.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	0	170,610	90.00
91.00	09100	-45,216	1,797,396	91.00
92.00	09200	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	-12,098	3,991,301	95.00
102.00	10200	0	0	102.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	0	0	113.00
118.00		-10,961,085	53,662,160	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	0	23,768	190.00
191.00	19100	0	637	191.00
192.00	19200	0	92,738	192.00
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	69,145	194.03
194.04	07954	0	0	194.04
194.05	07955	0	78,097	194.05
194.06	07956	0	0	194.06
194.07	07957	0	0	194.07
194.08	07958	0	0	194.08
194.09	07959	0	0	194.09
200.00		-10,961,085	53,926,545	200.00

RECLASSIFICATIONS

Provider CCN: 15-0091

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

Worksheet A-6

Date/Time Prepared:
5/18/2023 11:36 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - CAFETERIA & CATERING						
1.00	CAFETERIA	11.00	330,998	243,537	1.00	
	O		330,998	243,537		
B - INTEREST RECLASSIFICATION						
1.00		0.00	0	0	1.00	
	O		0	0		
C - INSURANCE RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	52,911	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	46,361	2.00	
	O		0	99,272		
E - LAUNDRY RECLASS						
1.00	LAUNDRY & LINEN SERVICE	8.00	52,509	0	1.00	
	O		52,509	0		
F - HOME OFFICE SALARY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	4,465,626	0	1.00	
	O		4,465,626	0		
G - PTO & BENEFITS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	87,874	0	1.00	
2.00	OPERATION OF PLANT	7.00	43,144	0	2.00	
3.00	HOUSEKEEPING	9.00	49,370	0	3.00	
4.00	DIETARY	10.00	67,006	0	4.00	
5.00	NURSING ADMINISTRATION	13.00	41,777	0	5.00	
7.00	ADULTS & PEDIATRICS	30.00	515,188	0	7.00	
8.00	OPERATING ROOM	50.00	138,723	0	8.00	
9.00	RADIOLOGY-DIAGNOSTIC	54.00	134,315	0	9.00	
10.00	LABORATORY	60.00	29	0	10.00	
11.00	RESPIRATORY THERAPY	65.00	74,705	0	11.00	
12.00	PHYSICAL THERAPY	66.00	132,988	0	12.00	
13.00	DRUGS CHARGED TO PATIENTS	73.00	67,293	0	13.00	
14.00	HYPERBARIC OXYGEN THERAPY	76.98	28,909	0	14.00	
15.00	CLINIC	90.00	15,312	0	15.00	
16.00	EMERGENCY	91.00	158,261	0	16.00	
17.00	AMBULANCE SERVICES	95.00	193,596	0	17.00	
18.00	PHYSICIANS' PRIVATE OFFICES	192.00	8,238	0	18.00	
19.00	COMMUNITY & VOLUNTEER SERVICES	194.05	1,060	0	19.00	
	O		1,757,788	0		
H - IMPLANTS						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	883,584	1.00	
	O		0	883,584		
I - OB RECLASS						
1.00	NURSERY	43.00	143,351	42,354	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	716,961	211,829	2.00	
	O		860,312	254,183		
J - THERAPY RECLASS						
1.00	OCCUPATIONAL THERAPY	67.00	246,567	10,438	1.00	
2.00	SPEECH PATHOLOGY	68.00	203,003	8,594	2.00	
	O		449,570	19,032		
500.00	Grand Total: Increases		7,916,803	1,499,608	500.00	

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA & CATERING							
1.00	DIETARY	10.00	330,998	243,537	0		1.00
	O		330,998	243,537			
B - INTEREST RECLASSIFICATION							
1.00		0.00	0	0	0		1.00
	O		0	0			
C - INSURANCE RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	99,272	12		1.00
2.00		0.00	0	0	12		2.00
	O		0	99,272			
E - LAUNDRY RECLASS							
1.00	HOUSEKEEPING	9.00	52,509	0	0		1.00
	O		52,509	0			
F - HOME OFFICE SALARY RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,465,626	0		1.00
	O		0	4,465,626			
G - PTO & BENEFITS RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,757,788	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
	O		1,757,788	0			
H - IMPLANTS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	883,584	0		1.00
	O		0	883,584			
I - OB RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	860,312	254,183	0		1.00
2.00		0.00	0	0	0		2.00
	O		860,312	254,183			
J - THERAPY RECLASS							
1.00	PHYSICAL THERAPY	66.00	449,570	19,032	0		1.00
2.00		0.00	0	0	0		2.00
	O		449,570	19,032			
500.00	Grand Total: Decreases		3,451,177	5,965,234			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0091

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

Worksheet A-7
Part I
Date/Time Prepared:
5/18/2023 11:36 am

		Acquisitions			Disposals and Retirements		
		Beginning Balances	Purchases	Donation			Total
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	1.00	
2.00	Land Improvements	625,461	20,520	0	20,520	2.00	
3.00	Buildings and Fixtures	10,098,058	74,980	0	74,980	3.00	
4.00	Building Improvements	32,500	0	0	0	4.00	
5.00	Fixed Equipment	2,024,291	162,103	0	162,103	5.00	
6.00	Movable Equipment	15,777,987	373,215	0	373,215	6.00	
7.00	HIT designated Assets	3,027,668	66,855	0	66,855	7.00	
8.00	Subtotal (sum of lines 1-7)	31,585,965	697,673	0	697,673	8.00	
9.00	Reconciling Items	3,255,352	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	28,330,613	697,673	0	697,673	10.00	
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0			1.00	
2.00	Land Improvements	645,981	414,646			2.00	
3.00	Buildings and Fixtures	10,173,038	1,283,279			3.00	
4.00	Building Improvements	32,500	0			4.00	
5.00	Fixed Equipment	2,186,394	210,823			5.00	
6.00	Movable Equipment	15,931,760	9,308,298			6.00	
7.00	HIT designated Assets	3,094,523	0			7.00	
8.00	Subtotal (sum of lines 1-7)	32,064,196	11,217,046			8.00	
9.00	Reconciling Items	3,255,352	0			9.00	
10.00	Total (line 8 minus line 9)	28,808,844	11,217,046			10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0091

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

Worksheet A-7
Part II
Date/Time Prepared:
5/18/2023 11:36 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	2,010,421	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,093,215	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,103,636	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	2,010,421				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,093,215				2.00
3.00	Total (sum of lines 1-2)	0	3,103,636				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0091

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

Worksheet A-7
Part III
Date/Time Prepared:
5/18/2023 11:36 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	13,037,914	0	13,037,914	0.409410	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	19,026,285	218,617	18,807,668	0.590590	0	2.00
3.00	Total (sum of lines 1-2)	32,064,199	218,617	31,845,582	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,816,297	-1,190,814	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,741,480	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,557,777	-1,190,814	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	52,911	0	0	2,678,394	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-3,502	46,361	0	0	1,784,339	2.00
3.00	Total (sum of lines 1-2)	-3,502	99,272	0	0	4,462,733	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7 Ref.		
			3.00	4.00	5.00		
1.00	2.00	3.00	4.00	5.00			
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-3,502		CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00 Investment income - other (chapter 2)		0			0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-16,244		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-2,326		OPERATION OF PLANT	7.00	0	8.00
9.00 Parking lot (chapter 21)		0			0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,308,468				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-7,893,529				0	12.00
13.00 Laundry and linen service		0			0.00	0	13.00
14.00 Cafeteria-employees and guests	A	-117,488		CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employees and others		0			0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0	16.00
17.00 Sale of drugs to other than patients		0			0.00	0	17.00
18.00 Sale of medical records and abstracts		0			0.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0			0.00	0	19.00
20.00 Vending machines		0			0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99

31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		68.00	31.00			
				Basis/Code (2)	Amount			Cost Center	Line #	Wkst. A-7 Ref.
32.00	CAH HIT Adjustment for Depreciation and Interest		0			0.00	0 32.00			
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.00			
33.01	TELEPHONE SERVICES	A	-3,208	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.01			
33.02	RENT EXPENSE OFFSET	A	-206,547	CAP REL COSTS-BLDG & FIXT		1.00	10 33.02			
33.03	RENT EXPENSE OFFSET	A	-984,267	CAP REL COSTS-BLDG & FIXT		1.00	10 33.03			
33.04	RENT EXPENSE OFFSET	A	0	CAP REL COSTS-BLDG & FIXT		1.00	10 33.04			
33.05	RENT EXPENSE OFFSET	A	0	CAP REL COSTS-BLDG & FIXT		1.00	10 33.05			
33.06	PHYSICIAN RECRUITMENT	A	-14,583	ADMINISTRATIVE & GENERAL		5.00	0 33.06			
33.07	SELF INSURANCE	A	0			0.00	0 33.07			
33.08	GUEST MEAL OFFSET	A	0	CAFETERIA		11.00	0 33.08			
33.09	AHA-IHA LOBBYING OFFSET	A	0	ADMINISTRATIVE & GENERAL		5.00	0 33.09			
33.10	LOBBYING OFFSET	A	-3,199	ADMINISTRATIVE & GENERAL		5.00	0 33.10			
33.11	LIQUOR OFFSET	A	-1,617	ADMINISTRATIVE & GENERAL		5.00	0 33.11			
33.12	OTHER OPERATING REVENUE	B	-21,954	ADMINISTRATIVE & GENERAL		5.00	0 33.12			
33.13	OTHER OPERATING REVENUE	B	-4,529	DIETARY		10.00	0 33.13			
33.14	OTHER OPERATING REVENUE	B	-300,930	CAFETERIA		11.00	0 33.14			
33.15	OTHER OPERATING REVENUE	B	0	NURSING ADMINISTRATION		13.00	0 33.15			
33.16	OTHER OPERATING REVENUE	B	-55,897	PHARMACY		15.00	0 33.16			
33.17	OTHER OPERATING REVENUE	B	-5,427	ADULTS & PEDIATRICS		30.00	0 33.17			
33.18	OTHER OPERATING REVENUE	B	-487	RADIOLOGY-DIAGNOSTIC		54.00	0 33.18			
33.19	OTHER OPERATING REVENUE	B	0	RESPIRATORY THERAPY		65.00	0 33.19			
33.20	OTHER OPERATING REVENUE	B	-23,023	PHYSICAL THERAPY		66.00	0 33.20			
33.21	OTHER OPERATING REVENUE	B	0	DRUGS CHARGED TO PATIENTS		73.00	0 33.21			
33.22	OTHER OPERATING REVENUE	B	-1,883	EMERGENCY		91.00	0 33.22			
33.23	OTHER OPERATING REVENUE	B	0	OPERATION OF PLANT		7.00	0 33.23			
33.24	DEPRECIATION	A	1,805,876	CAP REL COSTS-BLDG & FIXT		1.00	9 33.24			
33.25	DEPRECIATION	A	648,265	CAP REL COSTS-MVBLE EQUIP		2.00	9 33.25			
33.26	TELEMETRY COSTS	A	32,059	ADULTS & PEDIATRICS		30.00	0 33.26			
33.27	PHYSICIAN ADMINISTRATION SALARIES	A	40,750	ADMINISTRATIVE & GENERAL		5.00	0 33.27			
33.28	PPG SERVICES-OFFSET	A	0	ADMINISTRATIVE & GENERAL		5.00	0 33.28			
33.29	REMOVE HAF FEES FROM EXPENSE	A	-2,518,927	ADMINISTRATIVE & GENERAL		5.00	0 33.29			
33.30	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.30			
33.31	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.31			
33.32	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.32			
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,961,085				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: 15-0091

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

Worksheet A-8-1

Date/Time Prepared: 5/18/2023 11:36 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	11,874,633	10,819,968 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	PPG SUBSIDY	0	8,377,272 2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE ELIMINATION	0	570,922 3.00
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.			11,874,633	19,768,162 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		0.00	PARKVIEW HEALTH SYSTEM, INC.	100.00	6.00
7.00			0.00		0.00	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: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet A-8-1 Date/Time Prepared: 5/18/2023 11:36 am
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	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	1,054,665	0		1.00
2.00	-8,377,272	0		2.00
3.00	-570,922	0		3.00
4.00	0	0		4.00
5.00	-7,893,529			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			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: 15-0091

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

Worksheet A-8-2

Date/Time Prepared:
5/18/2023 11:36 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	DR. A	1,253,037	1,253,037	0	239,400	0	1.00
2.00	91.00	DR. B	43,333	43,333	0	0	0	2.00
3.00	95.00	DR. C	12,098	12,098	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,308,468	1,308,468	0	0	0	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	DR. A	0	0	0	0	0	1.00
2.00	91.00	DR. B	0	0	0	0	0	2.00
3.00	95.00	DR. C	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			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	DR. A	0	0	0	1,253,037		1.00
2.00	91.00	DR. B	0	0	0	43,333		2.00
3.00	95.00	DR. C	0	0	0	12,098		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,308,468		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0091

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

Worksheet B
Part I
Date/Time Prepared:
5/18/2023 11:36 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,678,394	2,678,394			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,784,339		1,784,339		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	6,255,487	2,577	0	6,258,064	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	14,121,717	149,939	59,342	1,583,719	15,914,717
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	1,297,340	598,761	56,494	117,571	2,070,166
8.00 00800	LAUNDRY & LINEN SERVICE	197,783	12,279	0	14,219	224,281
9.00 00900	HOUSEKEEPING	589,532	9,995	4,926	120,319	724,772
10.00 01000	DIETARY	518,303	95,496	5,849	92,966	712,614
11.00 01100	CAFETERIA	156,117	21,668	0	89,631	267,416
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	427,340	0	0	113,847	541,187
14.00 01400	CENTRAL SERVICES & SUPPLY	0	37,187	0	0	37,187
15.00 01500	PHARMACY	708,698	22,547	0	165,158	896,403
16.00 01600	MEDICAL RECORDS & LIBRARY	0	12,454	0	0	12,454
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING PROGRAM	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	4,415,469	491,144	211,325	915,678	6,033,616
43.00 04300	NURSERY	185,705	1,991	0	38,818	226,514
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	760,803	187,088	214,655	378,034	1,540,580
50.01 05001	OPERATING ROOM	0	0	0	0	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	928,790	0	0	194,146	1,122,936
53.00 05300	ANESTHESIOLOGY	1,253,037	0	0	0	1,253,037
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,950,266	234,484	385,680	366,020	2,936,450
60.00 06000	LABORATORY	2,895,779	35,528	0	80	2,931,387
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	899,985	42,985	88,687	203,579	1,235,236
66.00 06600	PHYSICAL THERAPY	897,729	508,205	115,267	240,667	1,761,868
67.00 06700	OCCUPATIONAL THERAPY	257,005	0	0	66,768	323,773
68.00 06800	SPEECH PATHOLOGY	211,597	0	0	54,971	266,568
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	555,618	0	0	0	555,618
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	883,584	0	0	0	883,584
73.00 07300	DRUGS CHARGED TO PATIENTS	2,128,282	0	0	18,222	2,146,504
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY	744,154	39,413	8,649	78,779	870,995
76.99 07699	LITHOTRIPSY	0	0	0	0	0
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	170,610	0	0	41,726	212,336
91.00 09100	EMERGENCY	1,797,396	99,947	91,770	431,275	2,420,388
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	3,991,301	69,318	537,472	906,532	5,504,623
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	53,662,160	2,673,006	1,780,116	6,232,725	53,627,210
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23,768	0	0	0	23,768
191.00 19100	RESEARCH	637	0	0	0	637
192.00 19200	PHYSICIANS' PRIVATE OFFICES	92,738	0	4,223	22,450	119,411
194.00 07950	OCC HEALTH	0	5,388	0	0	5,388
194.01 07951	PAIN CLINIC	0	0	0	0	0
194.02 07952	OCC HEALTH	0	0	0	0	0
194.03 07953	FOUNDATIO	69,145	0	0	0	69,145
194.04 07954	KIDS CAMPUS	0	0	0	0	0
194.05 07955	COMMUNITY & VOLUNTEER SERVICES	78,097	0	0	2,889	80,986
194.06 07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0
194.07 07957	MISC CATERING	0	0	0	0	0
194.08 07958	AUTISM CENTER	0	0	0	0	0
194.09 07959	HUNTINGTON BUA	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0091

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

Worksheet B
Part I
Date/Time Prepared:
5/18/2023 11:36 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
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)	53,926,545	2,678,394	1,784,339	6,258,064	53,926,545	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0091

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

Worksheet B
Part I
Date/Time Prepared:
5/18/2023 11:36 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	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
5.00	00500	ADMINISTRATIVE & GENERAL	15,914,717					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	866,733	0	2,936,899			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	93,902	0	18,712	336,895		8.00
9.00	00900	HOUSEKEEPING	303,446	0	15,232	0	1,043,450	9.00
10.00	01000	DIETARY	298,356	0	145,534	0	52,312	10.00
11.00	01100	CAFETERIA	111,961	0	33,022	0	11,870	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	226,583	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,569	0	56,673	0	20,371	14.00
15.00	01500	PHARMACY	375,304	0	34,361	0	12,351	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,214	0	18,980	0	6,822	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,526,145	0	748,497	76,583	269,043	30.00
43.00	04300	NURSERY	94,836	0	3,034	7,540	1,091	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	645,007	0	285,119	72,195	102,484	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	470,149	0	0	30,095	0	52.00
53.00	05300	ANESTHESIOLOGY	524,619	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,229,427	0	357,351	60,034	128,448	54.00
60.00	06000	LABORATORY	1,227,307	0	54,144	0	19,462	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	517,166	0	65,508	0	23,547	65.00
66.00	06600	PHYSICAL THERAPY	737,655	0	774,500	0	278,386	66.00
67.00	06700	OCCUPATIONAL THERAPY	135,557	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	111,606	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	232,625	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	369,937	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	898,694	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	364,666	0	60,064	0	21,590	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
77.00	07700	ALLOGENEI C HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	88,900	0	0	1,394	0	90.00
91.00	09100	EMERGENCY	1,013,363	0	152,317	89,054	54,750	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,304,665	0	105,640	0	37,972	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,789,392	0	2,928,688	336,895	1,040,499	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,951	0	0	0	0	190.00
191.00	19100	RESEARCH	267	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	49,995	0	0	0	0	192.00
194.00	07950	OCC HEALTH	2,256	0	8,211	0	2,951	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	28,949	0	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	33,907	0	0	0	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
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)	15,914,717	0	2,936,899	336,895	1,043,450	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0091		Period: From 01/01/2022 To 12/31/2022		Worksheet B Part I Date/Time Prepared: 5/18/2023 11:36 am	
Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,208,816					10.00
11.00	01100	CAFETERIA	0	424,269				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	8,631	0	776,401		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	129,800	14.00
15.00	01500	PHARMACY	0	10,957	0	0	1,782	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,208,816	79,686	0	347,198	10,271	30.00
43.00	04300	NURSERY	0	3,474	0	15,136	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	34,130	0	148,705	20,359	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,373	0	75,695	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,615	0	0	4,215	54.00
60.00	06000	LABORATORY	0	12	0	0	13	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	21,887	0	0	5,771	65.00
66.00	06600	PHYSICAL THERAPY	0	24,554	0	0	1,105	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,011	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,596	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	61,847	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	2,755	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	3,492	0	0	697	90.00
91.00	09100	EMERGENCY	0	43,531	0	189,667	6,989	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	122,219	0	0	12,739	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,208,816	420,168	0	776,401	128,543	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	995	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,030	0	0	258	192.00
194.00	07950	OCC HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	644	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	427	0	0	4	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
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)	1,208,816	424,269	0	776,401	129,800	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0091

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

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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
		15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200						12.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500						15.00
16.00	01600	1,331,158	43,470				16.00
17.00	01700	0	0	0			17.00
19.00	01900	0	0	0	0		19.00
20.00	02000	0	0	0		0	20.00
21.00	02100	0	0	0			21.00
22.00	02200	0	0	0			22.00
23.00	02300	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	3,144	0	0	0	30.00
43.00	04300	0	179	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	5,654	0	0	0	50.00
50.01	05001	0	0	0	0	0	50.01
52.00	05200	0	893	0	0	0	52.00
53.00	05300	0	707	0	0	0	53.00
54.00	05400	0	6,511	0	0	0	54.00
60.00	06000	0	6,130	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	1,722	0	0	0	65.00
66.00	06600	0	1,004	0	0	0	66.00
67.00	06700	0	322	0	0	0	67.00
68.00	06800	0	138	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	581	0	0	0	71.00
72.00	07200	0	910	0	0	0	72.00
73.00	07300	1,331,158	3,839	0	0	0	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	529	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
77.00	07700	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	173	0	0	0	90.00
91.00	09100	0	7,196	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	3,838	0	0	0	95.00
102.00	10200	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,331,158	43,470	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	0	0	0	194.09
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,331,158	43,470	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0091

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

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Cost Center Description	INTERNS & RESIDENTS		PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV			
	21.00	22.00			
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
6.00 00600	MAINTENANCE & REPAIRS				6.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
12.00 01200	MAINTENANCE OF PERSONNEL				12.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE				17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00 02000	NURSING PROGRAM				20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0		22.00
23.00 02300	PARAMED PRGM-(SPECIFY)			0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	0	0	11,302,999
43.00 04300	NURSERY	0	0	0	351,804
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	0	0	2,854,233
50.01 05001	OPERATING ROOM	0	0	0	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,717,141
53.00 05300	ANESTHESIOLOGY	0	0	0	1,778,363
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,758,051
60.00 06000	LABORATORY	0	0	0	4,238,455
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	0	0	0	1,870,837
66.00 06600	PHYSICAL THERAPY	0	0	0	3,579,072
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	467,663
68.00 06800	SPEECH PATHOLOGY	0	0	0	384,908
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	850,671
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,254,431
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,380,195
76.97 07697	CARDIAC REHABILITATION	0	0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	1,320,599
76.99 07699	LITHOTRIPSY	0	0	0	0
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000	CLINIC	0	0	0	306,992
91.00 09100	EMERGENCY	0	0	0	3,977,255
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0
OTHER REIMBURSABLE COST CENTERS					
95.00 09500	AMBULANCE SERVICES	0	0	0	8,091,696
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0
SPECIAL PURPOSE COST CENTERS					
113.00 11300	INTEREST EXPENSE				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	53,485,365
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	34,714
191.00 19100	RESEARCH	0	0	0	904
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	172,694
194.00 07950	OCC HEALTH	0	0	0	18,806
194.01 07951	PAIN CLINIC	0	0	0	0
194.02 07952	OCC HEALTH	0	0	0	0
194.03 07953	FOUNDATION	0	0	0	98,738
194.04 07954	KIDS CAMPUS	0	0	0	0
194.05 07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	115,324
194.06 07956	HUNTINGTON COLLEGE NURSE	0	0	0	0
194.07 07957	MISC CATERING	0	0	0	0
194.08 07958	AUTISM CENTER	0	0	0	0
194.09 07959	HUNTINGTON BUA	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0091

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Cost Center Description		INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
		21.00	22.00				
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	0	0	53,926,545	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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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
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
6.00	00600 MAINTENANCE & REPAIRS		6.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
12.00	01200 MAINTENANCE OF PERSONNEL		12.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000 NURSING PROGRAM		20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	11,302,999	30.00
43.00	04300 NURSERY	351,804	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	2,854,233	50.00
50.01	05001 OPERATING ROOM	0	50.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,717,141	52.00
53.00	05300 ANESTHESIOLOGY	1,778,363	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,758,051	54.00
60.00	06000 LABORATORY	4,238,455	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500 RESPIRATORY THERAPY	1,870,837	65.00
66.00	06600 PHYSICAL THERAPY	3,579,072	66.00
67.00	06700 OCCUPATIONAL THERAPY	467,663	67.00
68.00	06800 SPEECH PATHOLOGY	384,908	68.00
69.00	06900 ELECTROCARDIOLOGY	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	850,671	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,254,431	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,380,195	73.00
76.97	07697 CARDIAC REHABILITATION	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	1,320,599	76.98
76.99	07699 LI THOTRI PSY	0	76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	77.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	306,992	90.00
91.00	09100 EMERGENCY	3,977,255	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	8,091,696	95.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	102.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	53,485,365	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	34,714	190.00
191.00	19100 RESEARCH	904	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	172,694	192.00
194.00	07950 OCC HEALTH	18,806	194.00
194.01	07951 PAIN CLINIC	0	194.01
194.02	07952 OCC HEALTH	0	194.02
194.03	07953 FOUNDATIO	98,738	194.03
194.04	07954 KIDS CAMPUS	0	194.04
194.05	07955 COMMUNITY & VOLUNTEER SERVICES	115,324	194.05
194.06	07956 HUNTINGTON COLLEGE NURSE	0	194.06
194.07	07957 MISC CATERING	0	194.07
194.08	07958 AUTISM CENTER	0	194.08
194.09	07959 HUNTINGTON BUA	0	194.09
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	53,926,545	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0091

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

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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	2.00			
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	2,577	2,577	2,577	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,342,057	149,939	59,342	2,551,338	644 5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00 00700	OPERATION OF PLANT	0	598,761	56,494	655,255	49 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	12,279	0	12,279	6 8.00
9.00 00900	HOUSEKEEPING	0	9,995	4,926	14,921	50 9.00
10.00 01000	DIETARY	0	95,496	5,849	101,345	38 10.00
11.00 01100	CAFETERIA	0	21,668	0	21,668	37 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	47 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	37,187	0	37,187	0 14.00
15.00 01500	PHARMACY	0	22,547	0	22,547	68 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	12,454	0	12,454	0 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00 02000	NURSING PROGRAM	0	0	0	0	0 20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	491,144	211,325	702,469	379 30.00
43.00 04300	NURSERY	0	1,991	0	1,991	16 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	187,088	214,655	401,743	156 50.00
50.01 05001	OPERATING ROOM	0	0	0	0	0 50.01
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	80 52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	234,484	385,680	620,164	151 54.00
60.00 06000	LABORATORY	0	35,528	0	35,528	0 60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00 06500	RESPIRATORY THERAPY	0	42,985	88,687	131,672	84 65.00
66.00 06600	PHYSICAL THERAPY	0	508,205	115,267	623,472	100 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	28 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	23 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	8 73.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98 07698	HYPERBARI C OXYGEN THERAPY	0	39,413	8,649	48,062	33 76.98
76.99 07699	LITHOTRI PSY	0	0	0	0	0 76.99
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0 77.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	17 90.00
91.00 09100	EMERGENCY	0	99,947	91,770	191,717	178 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	69,318	537,472	606,790	375 95.00
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0 102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	2,342,057	2,673,006	1,780,116	6,795,179	2,567 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
191.00 19100	RESEARCH	0	0	0	0	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,223	4,223	9 192.00
194.00 07950	OCC HEALTH	0	5,388	0	5,388	0 194.00
194.01 07951	PAIN CLINIC	0	0	0	0	0 194.01
194.02 07952	OCC HEALTH	0	0	0	0	0 194.02
194.03 07953	FOUNDATIO	0	0	0	0	0 194.03
194.04 07954	KIDS CAMPUS	0	0	0	0	0 194.04
194.05 07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	1 194.05
194.06 07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0 194.06
194.07 07957	MISC CATERING	0	0	0	0	0 194.07
194.08 07958	AUTISM CENTER	0	0	0	0	0 194.08
194.09 07959	HUNTINGTON BUA	0	0	0	0	0 194.09
200.00	Cross Foot Adjustments				0	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0091

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

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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	2.00	2A	4.00	
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	2,342,057	2,678,394	1,784,339	6,804,790	2,577	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prepared: 5/18/2023 11:36 am		
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
			5.00	6.00	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
5.00	00500	ADMINISTRATIVE & GENERAL	2,551,982				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	138,985	0	794,289		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,058	0	5,061	32,404	8.00
9.00	00900	HOUSEKEEPING	48,659	0	4,119	0	67,749
10.00	01000	DIETARY	47,843	0	39,360	0	3,396
11.00	01100	CAFETERIA	17,954	0	8,931	0	771
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	36,334	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	2,497	0	15,327	0	1,323
15.00	01500	PHARMACY	60,182	0	9,293	0	802
16.00	01600	MEDICAL RECORDS & LIBRARY	836	0	5,133	0	443
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING PROGRAM	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	405,056	0	202,432	7,366	17,468
43.00	04300	NURSERY	15,207	0	821	725	71
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	103,430	0	77,111	6,944	6,654
50.01	05001	OPERATING ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	75,391	0	0	2,895	0
53.00	05300	ANESTHESIOLOGY	84,125	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	197,144	0	96,646	5,774	8,340
60.00	06000	LABORATORY	196,805	0	14,643	0	1,264
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	82,930	0	17,717	0	1,529
66.00	06600	PHYSICAL THERAPY	118,287	0	209,465	0	18,074
67.00	06700	OCCUPATIONAL THERAPY	21,737	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	17,897	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	37,303	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	59,321	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	144,110	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIIC OXYGEN THERAPY	58,476	0	16,244	0	1,402
76.99	07699	LITHOTRIpsy	0	0	0	0	0
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	14,256	0	0	134	0
91.00	09100	EMERGENCY	162,498	0	41,194	8,566	3,555
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	369,564	0	28,571	0	2,465
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,531,885	0	792,068	32,404	67,557
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,596	0	0	0	0
191.00	19100	RESEARCH	43	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,017	0	0	0	0
194.00	07950	OCC HEALTH	362	0	2,221	0	192
194.01	07951	PAIN CLINIC	0	0	0	0	0
194.02	07952	OCC HEALTH	0	0	0	0	0
194.03	07953	FOUNDATIO	4,642	0	0	0	0
194.04	07954	KIDS CAMPUS	0	0	0	0	0
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	5,437	0	0	0	0
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0
194.07	07957	MISC CATERING	0	0	0	0	0
194.08	07958	AUTISM CENTER	0	0	0	0	0
194.09	07959	HUNTINGTON BUA	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	2,551,982	0	794,289	32,404	67,749

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0091

Period:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	191,982					10.00
11.00	01100	CAFETERIA	0	49,361				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	1,004	0	37,385		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	56,334	14.00
15.00	01500	PHARMACY	0	1,275	0	0	773	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	191,982	9,271	0	16,718	4,458	30.00
43.00	04300	NURSERY	0	404	0	729	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,971	0	7,160	8,836	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,021	0	3,645	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,144	0	0	1,829	54.00
60.00	06000	LABORATORY	0	1	0	0	6	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,546	0	0	2,504	65.00
66.00	06600	PHYSICAL THERAPY	0	2,857	0	0	480	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	932	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	767	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	26,842	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	1,196	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	406	0	0	302	90.00
91.00	09100	EMERGENCY	0	5,065	0	9,133	3,033	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	14,219	0	0	5,529	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	191,982	48,883	0	37,385	55,788	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	432	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	353	0	0	112	192.00
194.00	07950	OCC HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	75	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	50	0	0	2	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
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)	191,982	49,361	0	37,385	56,334	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0091

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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
		15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200						12.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500	94,940					15.00
16.00	01600	0	18,866				16.00
17.00	01700	0	0	0			17.00
19.00	01900	0	0	0	0		19.00
20.00	02000	0	0	0		0	20.00
21.00	02100	0	0	0			21.00
22.00	02200	0	0	0			22.00
23.00	02300	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	1,368	0			30.00
43.00	04300	0	78	0			43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	2,461	0			50.00
50.01	05001	0	0	0			50.01
52.00	05200	0	389	0			52.00
53.00	05300	0	308	0			53.00
54.00	05400	0	2,834	0			54.00
60.00	06000	0	2,668	0			60.00
62.30	06250	0	0	0			62.30
65.00	06500	0	749	0			65.00
66.00	06600	0	437	0			66.00
67.00	06700	0	140	0			67.00
68.00	06800	0	60	0			68.00
69.00	06900	0	0	0			69.00
71.00	07100	0	253	0			71.00
72.00	07200	0	396	0			72.00
73.00	07300	94,940	1,671	0			73.00
76.97	07697	0	0	0			76.97
76.98	07698	0	230	0			76.98
76.99	07699	0	0	0			76.99
77.00	07700	0	0	0			77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	75	0			90.00
91.00	09100	0	3,078	0			91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	1,671	0			95.00
102.00	10200	0	0	0			102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		94,940	18,866	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0			190.00
191.00	19100	0	0	0			191.00
192.00	19200	0	0	0			192.00
194.00	07950	0	0	0			194.00
194.01	07951	0	0	0			194.01
194.02	07952	0	0	0			194.02
194.03	07953	0	0	0			194.03
194.04	07954	0	0	0			194.04
194.05	07955	0	0	0			194.05
194.06	07956	0	0	0			194.06
194.07	07957	0	0	0			194.07
194.08	07958	0	0	0			194.08
194.09	07959	0	0	0			194.09
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		94,940	18,866	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0091

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

Worksheet B
Part II
Date/Time Prepared:
5/18/2023 11:36 am

Cost Center Description	INTERNS & RESIDENTS		PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
	21.00	22.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000	NURSING PROGRAM					20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0				21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0			22.00
23.00 02300	PARAMED PRGM-(SPECIFY)			0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS				1,558,967	0 30.00
43.00 04300	NURSERY				20,042	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM				618,466	0 50.00
50.01 05001	OPERATING ROOM				0	0 50.01
52.00 05200	DELIVERY ROOM & LABOR ROOM				84,421	0 52.00
53.00 05300	ANESTHESIOLOGY				84,433	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC				937,026	0 54.00
60.00 06000	LABORATORY				250,915	0 60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0 62.30
65.00 06500	RESPIRATORY THERAPY				239,731	0 65.00
66.00 06600	PHYSICAL THERAPY				973,172	0 66.00
67.00 06700	OCCUPATIONAL THERAPY				22,837	0 67.00
68.00 06800	SPEECH PATHOLOGY				18,747	0 68.00
69.00 06900	ELECTROCARDIOLOGY				0	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT				64,398	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS				59,717	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS				240,729	0 73.00
76.97 07697	CARDIAC REHABILITATION				0	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY				125,643	0 76.98
76.99 07699	LITHOTRIPSY				0	0 76.99
77.00 07700	ALLOGENEIC HSCT ACQUISITION				0	0 77.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC				15,190	0 90.00
91.00 09100	EMERGENCY				428,017	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES				1,029,184	0 95.00
102.00 10200	OPIOID TREATMENT PROGRAM				0	0 102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	6,771,635	0 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				2,028	0 190.00
191.00 19100	RESEARCH				43	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES				12,714	0 192.00
194.00 07950	OCC HEALTH				8,163	0 194.00
194.01 07951	PAIN CLINIC				0	0 194.01
194.02 07952	OCC HEALTH				0	0 194.02
194.03 07953	FOUNDATION				4,717	0 194.03
194.04 07954	KIDS CAMPUS				0	0 194.04
194.05 07955	COMMUNITY & VOLUNTEER SERVICES				5,490	0 194.05
194.06 07956	HUNTINGTON COLLEGE NURSE				0	0 194.06
194.07 07957	MISC CATERING				0	0 194.07
194.08 07958	AUTISM CENTER				0	0 194.08
194.09 07959	HUNTINGTON BUA				0	0 194.09

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0091

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

Worksheet B
Part II
Date/Time Prepared:
5/18/2023 11:36 am

Cost Center Description	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments		
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV					
	21.00	22.00					23.00
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	0	0	0	6,804,790	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prepared: 5/18/2023 11:36 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
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
6.00	00600 MAINTENANCE & REPAIRS		6.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
12.00	01200 MAINTENANCE OF PERSONNEL		12.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000 NURSING PROGRAM		20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	1,558,967	30.00
43.00	04300 NURSERY	20,042	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	618,466	50.00
50.01	05001 OPERATING ROOM	0	50.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	84,421	52.00
53.00	05300 ANESTHESIOLOGY	84,433	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	937,026	54.00
60.00	06000 LABORATORY	250,915	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500 RESPIRATORY THERAPY	239,731	65.00
66.00	06600 PHYSICAL THERAPY	973,172	66.00
67.00	06700 OCCUPATIONAL THERAPY	22,837	67.00
68.00	06800 SPEECH PATHOLOGY	18,747	68.00
69.00	06900 ELECTROCARDIOLOGY	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	64,398	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	59,717	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	240,729	73.00
76.97	07697 CARDIAC REHABILITATION	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	125,643	76.98
76.99	07699 LI THOTRI PSY	0	76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	77.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	15,190	90.00
91.00	09100 EMERGENCY	428,017	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	1,029,184	95.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	102.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	6,771,635	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,028	190.00
191.00	19100 RESEARCH	43	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	12,714	192.00
194.00	07950 OCC HEALTH	8,163	194.00
194.01	07951 PAIN CLINIC	0	194.01
194.02	07952 OCC HEALTH	0	194.02
194.03	07953 FOUNDATIO	4,717	194.03
194.04	07954 KIDS CAMPUS	0	194.04
194.05	07955 COMMUNITY & VOLUNTEER SERVICES	5,490	194.05
194.06	07956 HUNTINGTON COLLEGE NURSE	0	194.06
194.07	07957 MISC CATERING	0	194.07
194.08	07958 AUTISM CENTER	0	194.08
194.09	07959 HUNTINGTON BUA	0	194.09
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	6,804,790	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0091

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

Worksheet B-1

Date/Time Prepared:
5/18/2023 11:36 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	137,207				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		896,588			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	132	0	23,110,406		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	7,681	29,818	5,848,527	-15,914,717	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	30,673	28,387	434,178	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	629	0	52,509	0	8.00
9.00 00900	HOUSEKEEPING	512	2,475	444,325	0	9.00
10.00 01000	DIETARY	4,892	2,939	343,313	0	10.00
11.00 01100	CAFETERIA	1,110	0	330,998	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	0	420,426	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,905	0	0	0	14.00
15.00 01500	PHARMACY	1,155	0	609,910	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	638	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING PROGRAM	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	25,160	106,186	3,381,506	0	30.00
43.00 04300	NURSERY	102	0	143,351	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	9,584	107,859	1,396,041	0	50.00
50.01 05001	OPERATING ROOM	0	0	0	0	50.01
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	716,961	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	12,012	193,795	1,351,675	0	54.00
60.00 06000	LABORATORY	1,820	0	295	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	2,202	44,563	751,798	0	65.00
66.00 06600	PHYSICAL THERAPY	26,034	57,919	888,757	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	246,567	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	203,003	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	67,293	0	73.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	2,019	4,346	290,923	0	76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	76.99
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	154,089	0	90.00
91.00 09100	EMERGENCY	5,120	46,112	1,592,656	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	3,551	270,067	3,347,729	0	95.00
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	136,931	894,466	23,016,830	-15,914,717	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	2,122	82,906	0	192.00
194.00 07950	OCC HEALTH	276	0	0	0	194.00
194.01 07951	PAIN CLINIC	0	0	0	0	194.01
194.02 07952	OCC HEALTH	0	0	0	0	194.02
194.03 07953	FOUNDATION	0	0	0	0	194.03
194.04 07954	KIDS CAMPUS	0	0	0	0	194.04
194.05 07955	COMMUNITY & VOLUNTEER SERVICES	0	0	10,670	0	194.05
194.06 07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	194.06
194.07 07957	MISC CATERING	0	0	0	0	194.07
194.08 07958	AUTISM CENTER	0	0	0	0	194.08
194.09 07959	HUNTINGTON BUA	0	0	0	0	194.09

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0091

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

Worksheet B-1

Date/Time Prepared:
5/18/2023 11:36 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	2,678,394	1,784,339	6,258,064		15,914,717	202.00
203.00	19.520826	1.990144	0.270790		0.418678	203.00
204.00			2,577		2,551,982	204.00
205.00			0.000112		0.067137	205.00
206.00						206.00
207.00						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0091

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

Worksheet B-1

Date/Time Prepared:
5/18/2023 11:36 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	0					6.00
7.00	00700		98,721				7.00
8.00	00800		629	234,386			8.00
9.00	00900	0	512	0	97,580		9.00
10.00	01000	0	4,892	0	4,892	21,554	10.00
11.00	01100	0	1,110	0	1,110	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	0	0	0	0	13.00
14.00	01400	0	1,905	0	1,905	0	14.00
15.00	01500	0	1,155	0	1,155	0	15.00
16.00	01600	0	638	0	638	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	25,160	53,281	25,160	21,554	30.00
43.00	04300	0	102	5,246	102	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	9,584	50,228	9,584	0	50.00
50.01	05001	0	0	0	0	0	50.01
52.00	05200	0	0	20,938	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	12,012	41,767	12,012	0	54.00
60.00	06000	0	1,820	0	1,820	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	2,202	0	2,202	0	65.00
66.00	06600	0	26,034	0	26,034	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	2,019	0	2,019	0	76.98
76.99	07699	0	0	0	0	0	76.99
77.00	07700	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	970	0	0	90.00
91.00	09100	0	5,120	61,956	5,120	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	3,551	0	3,551	0	95.00
102.00	10200	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		0	98,445	234,386	97,304	21,554	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	276	0	276	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	0	0	0	194.09
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0091

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

Worksheet B-1

Date/Time Prepared:
5/18/2023 11:36 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	0	2,936,899	336,895	1,043,450	1,208,816	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	29.749486	1.437351	10.693277	56.083140	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	794,289	32,404	67,749	191,982	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	8.045796	0.138251	0.694292	8.907024	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0091

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

Worksheet B-1

Date/Time Prepared:
5/18/2023 11:36 am

Cost Center Description		CAFETERIA (HOURS OF SERVICE)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	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
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	421,464					11.00
12.00	01200	0	0				12.00
13.00	01300	8,574	0	177,015			13.00
14.00	01400	0	0	0	3,020,510		14.00
15.00	01500	10,885	0	0	41,467	2,060,989	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	79,159	0	79,159	239,019	0	30.00
43.00	04300	3,451	0	3,451	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	33,904	0	33,904	473,763	0	50.00
50.01	05001	0	0	0	0	0	50.01
52.00	05200	17,258	0	17,258	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	35,380	0	0	98,084	0	54.00
60.00	06000	12	0	0	305	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	21,742	0	0	134,286	0	65.00
66.00	06600	24,392	0	0	25,721	0	66.00
67.00	06700	7,958	0	0	0	0	67.00
68.00	06800	6,552	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	1,439,202	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	2,060,989	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	64,115	0	76.98
76.99	07699	0	0	0	0	0	76.99
77.00	07700	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	3,469	0	0	16,217	0	90.00
91.00	09100	43,243	0	43,243	162,642	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	121,411	0	0	296,443	0	95.00
102.00	10200	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		417,390	0	177,015	2,991,264	2,060,989	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	23,148	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	3,010	0	0	6,012	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	640	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	424	0	0	86	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	0	0	0	194.09
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0091

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

Worksheet B-1

Date/Time Prepared:
5/18/2023 11:36 am

Cost Center Description		CAFETERIA (HOURS OF SERVICE)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	424,269	0	776,401	129,800	1,331,158	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.006655	0.000000	4.386075	0.042973	0.645883	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	49,361	0	37,385	56,334	94,940	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.117118	0.000000	0.211197	0.018650	0.046065	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0091

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

Worksheet B-1

Date/Time Prepared:
5/18/2023 11:36 am

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS	
	16.00	17.00	19.00	20.00	SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME) 21.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	255,809,749				16.00
17.00 01700	SOCIAL SERVICE	0	0			17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
20.00 02000	NURSING PROGRAM	0	0	0		20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0			22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	18,492,627	0	0	0	30.00
43.00 04300	NURSERY	1,050,668	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	33,255,933	0	0	0	50.00
50.01 05001	OPERATING ROOM	0	0	0	0	50.01
52.00 05200	DELIVERY ROOM & LABOR ROOM	5,254,859	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	4,156,236	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	38,300,893	0	0	0	54.00
60.00 06000	LABORATORY	36,060,742	0	0	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	10,126,586	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	5,905,608	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	1,894,215	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	813,313	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,415,794	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	5,354,944	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	22,581,368	0	0	0	73.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	3,111,118	0	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	76.99
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	1,018,993	0	0	0	90.00
91.00 09100	EMERGENCY	42,441,167	0	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	22,574,685	0	0	0	95.00
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00 11800	SUBTOTALS (SUM OF LINES 1 through 117)	255,809,749	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	OCC HEALTH	0	0	0	0	194.00
194.01 07951	PAIN CLINIC	0	0	0	0	194.01
194.02 07952	OCC HEALTH	0	0	0	0	194.02
194.03 07953	FOUNDATION	0	0	0	0	194.03
194.04 07954	KIDS CAMPUS	0	0	0	0	194.04
194.05 07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	194.05
194.06 07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	194.06
194.07 07957	MISC CATERING	0	0	0	0	194.07
194.08 07958	AUTISM CENTER	0	0	0	0	194.08
194.09 07959	HUNTINGTON BUA	0	0	0	0	194.09

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0091

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

Worksheet B-1

Date/Time Prepared:
5/18/2023 11:36 am

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
	16.00	17.00	19.00	20.00	21.00	
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	43,470	0	0	0	0 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000170	0.000000	0.000000	0.000000	0.000000 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	18,866	0	0	0	0 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000074	0.000000	0.000000	0.000000	0.000000 205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0091

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

Worksheet B-1
Date/Time Prepared:
5/18/2023 11:36 am

Cost Center Description	INTERNS & RESIDENTS	PARAMED PRGM (ASSIGNED TIME)	
	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
	22.00		
GENERAL SERVICE COST CENTERS			
1.00 00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00 00500	ADMINISTRATIVE & GENERAL		5.00
6.00 00600	MAINTENANCE & REPAIRS		6.00
7.00 00700	OPERATION OF PLANT		7.00
8.00 00800	LAUNDRY & LINEN SERVICE		8.00
9.00 00900	HOUSEKEEPING		9.00
10.00 01000	DIETARY		10.00
11.00 01100	CAFETERIA		11.00
12.00 01200	MAINTENANCE OF PERSONNEL		12.00
13.00 01300	NURSING ADMINISTRATION		13.00
14.00 01400	CENTRAL SERVICES & SUPPLY		14.00
15.00 01500	PHARMACY		15.00
16.00 01600	MEDICAL RECORDS & LIBRARY		16.00
17.00 01700	SOCIAL SERVICE		17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00 02000	NURSING PROGRAM		20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	22.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 03000	ADULTS & PEDIATRICS	0	30.00
43.00 04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS			
50.00 05000	OPERATING ROOM	0	50.00
50.01 05001	OPERATING ROOM	0	50.01
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00 05300	ANESTHESIOLOGY	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00 06000	LABORATORY	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00 06500	RESPIRATORY THERAPY	0	65.00
66.00 06600	PHYSICAL THERAPY	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.97 07697	CARDIAC REHABILITATION	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99 07699	LITHOTRIPSY	0	76.99
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	77.00
OUTPATIENT SERVICE COST CENTERS			
90.00 09000	CLINIC	0	90.00
91.00 09100	EMERGENCY	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00 09500	AMBULANCE SERVICES	0	95.00
102.00 10200	OPIOID TREATMENT PROGRAM	0	102.00
SPECIAL PURPOSE COST CENTERS			
113.00 11300	INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
NONREIMBURSABLE COST CENTERS			
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
191.00 19100	RESEARCH	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00 07950	OCC HEALTH	0	194.00
194.01 07951	PAIN CLINIC	0	194.01
194.02 07952	OCC HEALTH	0	194.02
194.03 07953	FOUNDATIO	0	194.03
194.04 07954	KIDS CAMPUS	0	194.04
194.05 07955	COMMUNITY & VOLUNTEER SERVICES	0	194.05
194.06 07956	HUNTINGTON COLLEGE NURSE	0	194.06
194.07 07957	MISC CATERING	0	194.07
194.08 07958	AUTISM CENTER	0	194.08
194.09 07959	HUNTINGTON BUA	0	194.09

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0091

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

Worksheet B-1
Date/Time Prepared:
5/18/2023 11:36 am

Cost Center Description	INTERNS & RESIDENTS	PARAMED PRGM (ASSIGNED TIME)	
	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
	22.00	23.00	
200.00 Cross Foot Adjustments			200.00
201.00 Negative Cost Centers			201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	0	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	0	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/18/2023 11:36 am
		Title XVIII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		11,302,999	0	11,302,999	30.00
43.00	04300 NURSERY		351,804	0	351,804	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		2,854,233	0	2,854,233	50.00
50.01	05001 OPERATING ROOM		0	0	0	50.01
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,717,141	0	1,717,141	52.00
53.00	05300 ANESTHESIOLOGY		1,778,363	0	1,778,363	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,758,051	0	4,758,051	54.00
60.00	06000 LABORATORY		4,238,455	0	4,238,455	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	1,870,837	0	1,870,837	65.00
66.00	06600 PHYSICAL THERAPY	0	3,579,072	0	3,579,072	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	467,663	0	467,663	67.00
68.00	06800 SPEECH PATHOLOGY	0	384,908	0	384,908	68.00
69.00	06900 ELECTROCARDIOLOGY		0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		850,671	0	850,671	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		1,254,431	0	1,254,431	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		4,380,195	0	4,380,195	73.00
76.97	07697 CARDIAC REHABILITATION		0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY		1,320,599	0	1,320,599	76.98
76.99	07699 LI THOTRIPSY		0	0	0	76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION		0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		306,992	0	306,992	90.00
91.00	09100 EMERGENCY		3,977,255	0	3,977,255	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		3,495,080	0	3,495,080	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		8,091,696	0	8,091,696	95.00
102.00	10200 OPIOID TREATMENT PROGRAM		0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		56,980,445	0	56,980,445	200.00
201.00	Less Observation Beds		3,495,080		3,495,080	201.00
202.00	Total (see instructions)		53,485,365	0	53,485,365	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/18/2023 11:36 am
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,240,424		12,240,424	30.00
43.00	04300	NURSERY	1,050,668		1,050,668	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,900,148	27,355,785	33,255,933	50.00
50.01	05001	OPERATING ROOM	0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,254,859	0	5,254,859	52.00
53.00	05300	ANESTHESIOLOGY	467,428	3,688,808	4,156,236	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,278,476	35,022,417	38,300,893	54.00
60.00	06000	LABORATORY	5,408,642	30,652,100	36,060,742	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,061,864	8,064,722	10,126,586	65.00
66.00	06600	PHYSICAL THERAPY	550,433	5,355,175	5,905,608	66.00
67.00	06700	OCCUPATIONAL THERAPY	325,656	1,568,559	1,894,215	67.00
68.00	06800	SPEECH PATHOLOGY	83,046	730,267	813,313	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	774,425	2,641,369	3,415,794	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	906,326	4,448,618	5,354,944	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,865,999	17,715,369	22,581,368	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	33,298	3,077,820	3,111,118	76.98
76.99	07699	LITHOTRIPSY	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,999	1,012,994	1,018,993	90.00
91.00	09100	EMERGENCY	4,306,700	38,134,467	42,441,167	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,252,203	6,252,203	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	22,574,685	22,574,685	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	47,514,391	208,295,358	255,809,749	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	47,514,391	208,295,358	255,809,749	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/18/2023 11:36 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.085826		50.00
50.01	05001 OPERATING ROOM	0.000000		50.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.326772		52.00
53.00	05300 ANESTHESIOLOGY	0.427878		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.124228		54.00
60.00	06000 LABORATORY	0.117537		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500 RESPIRATORY THERAPY	0.184745		65.00
66.00	06600 PHYSICAL THERAPY	0.606046		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.246890		67.00
68.00	06800 SPEECH PATHOLOGY	0.473259		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.249040		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.234257		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.193974		73.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.424477		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.301270		90.00
91.00	09100 EMERGENCY	0.093712		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.559016		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.358441		95.00
102.00	10200 OPIOID TREATMENT PROGRAM			102.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0091

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

Worksheet C
Part I
Date/Time Prepared:
5/18/2023 11:36 am

		Title XIX		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	11,302,999		11,302,999	0	11,302,999	30.00
43.00	04300 NURSERY	351,804		351,804	0	351,804	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,854,233		2,854,233	0	2,854,233	50.00
50.01	05001 OPERATING ROOM	0		0	0	0	50.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,717,141		1,717,141	0	1,717,141	52.00
53.00	05300 ANESTHESIOLOGY	1,778,363		1,778,363	0	1,778,363	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,758,051		4,758,051	0	4,758,051	54.00
60.00	06000 LABORATORY	4,238,455		4,238,455	0	4,238,455	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	1,870,837	0	1,870,837	0	1,870,837	65.00
66.00	06600 PHYSICAL THERAPY	3,579,072	0	3,579,072	0	3,579,072	66.00
67.00	06700 OCCUPATIONAL THERAPY	467,663	0	467,663	0	467,663	67.00
68.00	06800 SPEECH PATHOLOGY	384,908	0	384,908	0	384,908	68.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	850,671		850,671	0	850,671	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,254,431		1,254,431	0	1,254,431	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,380,195		4,380,195	0	4,380,195	73.00
76.97	07697 CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	1,320,599		1,320,599	0	1,320,599	76.98
76.99	07699 LI THOTRIPSY	0		0	0	0	76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	306,992		306,992	0	306,992	90.00
91.00	09100 EMERGENCY	3,977,255		3,977,255	0	3,977,255	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3,495,080		3,495,080	0	3,495,080	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	8,091,696		8,091,696	0	8,091,696	95.00
102.00	10200 OPIOID TREATMENT PROGRAM	0		0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	56,980,445	0	56,980,445	0	56,980,445	200.00
201.00	Less Observation Beds	3,495,080		3,495,080		3,495,080	201.00
202.00	Total (see instructions)	53,485,365	0	53,485,365	0	53,485,365	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/18/2023 11:36 am
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Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,240,424		12,240,424		30.00
43.00	04300	NURSERY	1,050,668		1,050,668		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,900,148	27,355,785	33,255,933	0.085826	50.00
50.01	05001	OPERATING ROOM	0	0	0	0.000000	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,254,859	0	5,254,859	0.326772	52.00
53.00	05300	ANESTHESIOLOGY	467,428	3,688,808	4,156,236	0.427878	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,278,476	35,022,417	38,300,893	0.124228	54.00
60.00	06000	LABORATORY	5,408,642	30,652,100	36,060,742	0.117537	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	2,061,864	8,064,722	10,126,586	0.184745	65.00
66.00	06600	PHYSICAL THERAPY	550,433	5,355,175	5,905,608	0.606046	66.00
67.00	06700	OCCUPATIONAL THERAPY	325,656	1,568,559	1,894,215	0.246890	67.00
68.00	06800	SPEECH PATHOLOGY	83,046	730,267	813,313	0.473259	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	774,425	2,641,369	3,415,794	0.249040	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	906,326	4,448,618	5,354,944	0.234257	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,865,999	17,715,369	22,581,368	0.193974	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	33,298	3,077,820	3,111,118	0.424477	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	5,999	1,012,994	1,018,993	0.301270	90.00
91.00	09100	EMERGENCY	4,306,700	38,134,467	42,441,167	0.093712	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,252,203	6,252,203	0.559016	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	22,574,685	22,574,685	0.358441	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	47,514,391	208,295,358	255,809,749		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	47,514,391	208,295,358	255,809,749		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/18/2023 11:36 am
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.085826		50.00
50.01	05001 OPERATING ROOM	0.000000		50.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.326772		52.00
53.00	05300 ANESTHESIOLOGY	0.427878		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.124228		54.00
60.00	06000 LABORATORY	0.117537		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500 RESPIRATORY THERAPY	0.184745		65.00
66.00	06600 PHYSICAL THERAPY	0.606046		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.246890		67.00
68.00	06800 SPEECH PATHOLOGY	0.473259		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.249040		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.234257		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.193974		73.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.424477		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.301270		90.00
91.00	09100 EMERGENCY	0.093712		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.559016		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.358441		95.00
102.00	10200 OPIOID TREATMENT PROGRAM			102.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-0091

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

Worksheet C Part II Date/Time Prepared: 5/18/2023 11:36 am

Cost Center Description		Title XIX			Hospital	PPS		
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,854,233	618,466	2,235,767	0	0	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,717,141	84,421	1,632,720	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,778,363	84,433	1,693,930	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,758,051	937,026	3,821,025	0	0	54.00
60.00	06000	LABORATORY	4,238,455	250,915	3,987,540	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,870,837	239,731	1,631,106	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,579,072	973,172	2,605,900	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	467,663	22,837	444,826	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	384,908	18,747	366,161	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	850,671	64,398	786,273	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,254,431	59,717	1,194,714	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,380,195	240,729	4,139,466	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,320,599	125,643	1,194,956	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	306,992	15,190	291,802	0	0	90.00
91.00	09100	EMERGENCY	3,977,255	428,017	3,549,238	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,495,080	482,059	3,013,021	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	8,091,696	1,029,184	7,062,512	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	45,325,642	5,674,685	39,650,957	0	0	200.00
201.00		Less Observation Beds	3,495,080	482,059	3,013,021	0	0	201.00
202.00		Total (line 200 minus line 201)	41,830,562	5,192,626	36,637,936	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-0091

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

Worksheet C Part II Date/Time Prepared: 5/18/2023 11:36 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2,854,233	33,255,933	0.085826		50.00
50.01	05001 OPERATING ROOM	0	0	0.000000		50.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,717,141	5,254,859	0.326772		52.00
53.00	05300 ANESTHESIOLOGY	1,778,363	4,156,236	0.427878		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,758,051	38,300,893	0.124228		54.00
60.00	06000 LABORATORY	4,238,455	36,060,742	0.117537		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000		62.30
65.00	06500 RESPIRATORY THERAPY	1,870,837	10,126,586	0.184745		65.00
66.00	06600 PHYSICAL THERAPY	3,579,072	5,905,608	0.606046		66.00
67.00	06700 OCCUPATIONAL THERAPY	467,663	1,894,215	0.246890		67.00
68.00	06800 SPEECH PATHOLOGY	384,908	813,313	0.473259		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	850,671	3,415,794	0.249040		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,254,431	5,354,944	0.234257		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,380,195	22,581,368	0.193974		73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	1,320,599	3,111,118	0.424477		76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000		76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.000000		77.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	306,992	1,018,993	0.301270		90.00
91.00	09100 EMERGENCY	3,977,255	42,441,167	0.093712		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,495,080	6,252,203	0.559016		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	8,091,696	22,574,685	0.358441		95.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0.000000		102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (sum of lines 50 thru 199)	45,325,642	242,518,657			200.00
201.00	Less Observation Beds	3,495,080	0			201.00
202.00	Total (line 200 minus line 201)	41,830,562	242,518,657			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0091		Period: From 01/01/2022 To 12/31/2022		Worksheet D Part I Date/Time Prepared: 5/18/2023 11:36 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,558,967	0	1,558,967	6,054	257.51	30.00
43.00	NURSERY	20,042		20,042	605	33.13	43.00
200.00	Total (lines 30 through 199)	1,579,009		1,579,009	6,659		200.00
INPATIENT ROUTINE SERVICE COST CENTERS							
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	982	252,875				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	982	252,875				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Prepared: 5/18/2023 11:36 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	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	618,466	33,255,933	0.018597	545,203	10,139	50.00
50.01	05001 OPERATING ROOM	0	0	0.000000	0	0	50.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	84,421	5,254,859	0.016065	0	0	52.00
53.00	05300 ANESTHESIOLOGY	84,433	4,156,236	0.020315	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	937,026	38,300,893	0.024465	1,064,768	26,050	54.00
60.00	06000 LABORATORY	250,915	36,060,742	0.006958	1,303,099	9,067	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	239,731	10,126,586	0.023673	350,456	8,296	65.00
66.00	06600 PHYSICAL THERAPY	973,172	5,905,608	0.164788	192,141	31,663	66.00
67.00	06700 OCCUPATIONAL THERAPY	22,837	1,894,215	0.012056	118,902	1,433	67.00
68.00	06800 SPEECH PATHOLOGY	18,747	813,313	0.023050	22,092	509	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	64,398	3,415,794	0.018853	232,246	4,379	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	59,717	5,354,944	0.011152	422,013	4,706	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	240,729	22,581,368	0.010661	1,100,693	11,734	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	125,643	3,111,118	0.040385	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	15,190	1,018,993	0.014907	0	0	90.00
91.00	09100 EMERGENCY	428,017	42,441,167	0.010085	1,158,603	11,685	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	482,059	6,252,203	0.077102	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	4,645,501	219,943,972		6,510,216	119,661	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-0091		Period: From 01/01/2022 To 12/31/2022		Worksheet D Part III Date/Time Prepared: 5/18/2023 11:36 am		
Title XVIII			Hospital		PPS				
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of col. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	6,054	0.00	982	30.00	
43.00	04300	NURSERY	0	0	605	0.00	0	43.00	
200.00		Total (lines 30 through 199)	0	0	6,659	0.00	982	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
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/18/2023 11:36 am
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Cost Center Description	Title XVIII			Hospital		Allied Health Post-Stepdown Adjustments	Allied Health PPS	
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program					
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0	50.01
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
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 PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
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
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/18/2023 11:36 am
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Cost Center Description	Title XVIII			Hospital	PPS			
	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)			
	4.00	5.00	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	33,255,933	0.000000	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0.000000	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,254,859	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,156,236	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	38,300,893	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	36,060,742	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,126,586	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,905,608	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,894,215	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	813,313	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,415,794	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,354,944	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	22,581,368	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	3,111,118	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	1,018,993	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	42,441,167	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	6,252,203	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	219,943,972		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/18/2023 11:36 am
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Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	545,203	0	4,077,413	0	50.00
50.01	05001 OPERATING ROOM	0.000000	0	0	0	0	50.01
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	1,064,768	0	5,626,184	0	54.00
60.00	06000 LABORATORY	0.000000	1,303,099	0	4,973,923	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.000000	350,456	0	908,968	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	192,141	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	118,902	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	22,092	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	232,246	0	550,509	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	422,013	0	1,152,083	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	1,100,693	0	4,472,409	0	73.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	1,158,603	0	4,900,351	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	399,641	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		6,510,216	0	27,061,481	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/18/2023 11:36 am
Title XVIII		Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.085826	4,077,413	0	0	349,948	50.00
50.01 05001 OPERATING ROOM	0.000000	0	0	0	0	50.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.326772	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.427878	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.124228	5,626,184	0	0	698,930	54.00
60.00 06000 LABORATORY	0.117537	4,973,923	0	0	584,620	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	0.184745	908,968	0	0	167,927	65.00
66.00 06600 PHYSICAL THERAPY	0.606046	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.246890	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.473259	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 PATIENT	0.249040	550,509	0	0	137,099	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.234257	1,152,083	0	0	269,884	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.193974	4,472,409	0	0	867,531	73.00
76.97 07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.424477	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.301270	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.093712	4,900,351	0	0	459,222	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.559016	399,641	0	0	223,406	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0.358441	0	0	0	0	95.00
200.00	Subtotal (see instructions)	27,061,481	0	0	3,758,567	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)	27,061,481	0	0	3,758,567	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/18/2023 11:36 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
50.01	05001	OPERATING ROOM	0	0	50.01
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
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
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 PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
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
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
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 CAPITAL COSTS		Provider CCN: 15-0091		Period: From 01/01/2022 To 12/31/2022		Worksheet D Part I Date/Time Prepared: 5/18/2023 11:36 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XIX							
Hospital							
PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,558,967	0	1,558,967	6,054	257.51	30.00
43.00	NURSERY	20,042		20,042	605	33.13	43.00
200.00	Total (lines 30 through 199)	1,579,009		1,579,009	6,659		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	118	30,386				
43.00	NURSERY	25	828				
200.00	Total (lines 30 through 199)	143	31,214				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Prepared: 5/18/2023 11:36 am
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Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. C, 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	618,466	33,255,933	0.018597	370,053	6,882	50.00
50.01	05001	OPERATING ROOM	0	0	0.000000	0	0	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	84,421	5,254,859	0.016065	140,631	2,259	52.00
53.00	05300	ANESTHESIOLOGY	84,433	4,156,236	0.020315	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	937,026	38,300,893	0.024465	47,918	1,172	54.00
60.00	06000	LABORATORY	250,915	36,060,742	0.006958	138,717	965	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	239,731	10,126,586	0.023673	32,082	759	65.00
66.00	06600	PHYSICAL THERAPY	973,172	5,905,608	0.164788	14,231	2,345	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,837	1,894,215	0.012056	7,095	86	67.00
68.00	06800	SPEECH PATHOLOGY	18,747	813,313	0.023050	972	22	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	64,398	3,415,794	0.018853	31,445	593	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	59,717	5,354,944	0.011152	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	240,729	22,581,368	0.010661	139,188	1,484	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	125,643	3,111,118	0.040385	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	15,190	1,018,993	0.014907	0	0	90.00
91.00	09100	EMERGENCY	428,017	42,441,167	0.010085	85,859	866	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	482,059	6,252,203	0.077102	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	4,645,501	219,943,972		1,008,191	17,433	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-0091		Period: From 01/01/2022 To 12/31/2022		Worksheet D Part III Date/Time Prepared: 5/18/2023 11:36 am		
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
			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	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of col.s. 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	6,054	0.00	118	30.00	
43.00	04300	NURSERY	0	0	605	0.00	25	43.00	
200.00		Total (lines 30 through 199)	0	0	6,659		143	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
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/18/2023 11:36 am
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Cost Center Description	Title XIX			Hospital		Allied Health Post-Stepdown Adjustments	Allied Health PPS	
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program					
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0	50.01
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
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 PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
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
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/18/2023 11:36 am
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Cost Center Description	Title XIX			Hospital	PPS			
	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)			
	4.00	5.00	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	33,255,933	0.000000	50.00
50.01	05001	OPERATING ROOM	0	0	0	0	0.000000	50.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,254,859	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,156,236	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	38,300,893	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	36,060,742	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,126,586	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,905,608	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,894,215	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	813,313	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,415,794	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,354,944	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	22,581,368	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	3,111,118	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	1,018,993	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	42,441,167	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	6,252,203	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	219,943,972		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/18/2023 11:36 am
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Cost Center Description	Title XIX			Hospital		PPS	
	Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
	9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0.000000	370,053	0	0	0	0	50.00
50.01 05001 OPERATING ROOM	0.000000	0	0	0	0	0	50.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	140,631	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.000000	47,918	0	0	0	0	54.00
60.00 06000 LABORATORY	0.000000	138,717	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	0.000000	32,082	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.000000	14,231	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	7,095	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	972	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	31,445	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	139,188	0	0	0	0	73.00
76.97 07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0	0	76.99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0.000000	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.000000	85,859	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES							95.00
200.00 Total (lines 50 through 199)		1,008,191	0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/18/2023 11:36 am
Title XIX		Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.085826	0	0	477,078	0
50.01 05001 OPERATING ROOM	0.000000	0	0	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.326772	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.427878	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.124228	0	0	419,812	0
60.00 06000 LABORATORY	0.117537	0	0	380,776	0
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.184745	0	0	0	0
66.00 06600 PHYSICAL THERAPY	0.606046	0	0	87,399	0
67.00 06700 OCCUPATIONAL THERAPY	0.246890	0	0	71,818	0
68.00 06800 SPEECH PATHOLOGY	0.473259	0	0	79,363	0
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.249040	0	0	41,941	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.234257	0	0	9,439	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.193974	0	0	93,763	0
76.97 07697 CARDIAC REHABILITATION	0.000000	0	0	0	0
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.424477	0	0	0	0
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0.301270	0	0	0	0
91.00 09100 EMERGENCY	0.093712	0	0	774,208	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.559016	0	0	75,736	0
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0.358441	0	0	0	0
200.00 Subtotal (see instructions)		0	0	2,511,333	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0	0
202.00 Net Charges (line 200 - line 201)		0	0	2,511,333	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/18/2023 11:36 am
		Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	40,946	50.00
50.01	05001 OPERATING ROOM	0	0	50.01
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	52,152	54.00
60.00	06000 LABORATORY	0	44,755	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	52,968	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	17,731	67.00
68.00	06800 SPEECH PATHOLOGY	0	37,559	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,445	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2,211	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	18,188	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	77.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	72,553	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	42,338	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0		95.00
200.00	Subtotal (see instructions)	0	391,846	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	391,846	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/18/2023 11:36 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,054	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,054	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,182	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)		982	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		11,302,999	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)		11,302,999	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)		11,302,999	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)		1,867.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,833,423	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,833,423	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/18/2023 11:36 am
Title XVIII			Hospital	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,032,010
48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0
49.00 Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					2,865,433
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					252,875
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					119,661
52.00 Total Program excludable cost (sum of lines 50 and 51)					372,536
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,492,897
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
55.01 Permanent adjustment amount per discharge					0.00
55.02 Adjustment amount per discharge (contractor use only)					0.00
56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					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 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00
61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0
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)					1,872
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,867.03

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0091		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/18/2023 11:36 am	
Title XVIII		Hospital		PPS			
Cost Center Description						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,495,080	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,558,967	11,302,999	0.137925	3,495,080	482,059	90.00
91.00	Nursing Program cost	0	11,302,999	0.000000	3,495,080	0	91.00
92.00	Allied health cost	0	11,302,999	0.000000	3,495,080	0	92.00
93.00	All other Medical Education	0	11,302,999	0.000000	3,495,080	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/18/2023 11:36 am
Cost Center Description		Title XIX	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			6,054 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			6,054 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			4,182 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)			118 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)			605 15.00
16.00	Nursery days (title V or XIX only)			25 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			11,302,999 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)			11,302,999 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)			11,302,999 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)			1,867.03 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			220,310 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)			220,310 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/18/2023 11:36 am	
			Title XIX	Hospital	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	351,804	605	581.49	25	14,537	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						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)					159,611	48.00
48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00 Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					394,458	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)					31,214	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					17,433	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					48,647	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					345,811	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
55.01 Permanent adjustment amount per discharge					0.00	55.01
55.02 Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only): for CAH, see instructions					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					1,872	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,867.03	88.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0091		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/18/2023 11:36 am	
Cost Center Description		Title XIX		Hospital		PPS	
Cost Center Description		Cost		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,495,080	89.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,558,967	11,302,999	0.137925		3,495,080	482,059 90.00
91.00	Nursing Program cost	0	11,302,999	0.000000		3,495,080	0 91.00
92.00	Allied health cost	0	11,302,999	0.000000		3,495,080	0 92.00
93.00	All other Medical Education	0	11,302,999	0.000000		3,495,080	0 93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/18/2023 11:36 am
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		2,359,274		30.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.085826	545,203	46,793	50.00
50.01	05001 OPERATING ROOM	0.000000	0	0	50.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.326772	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.427878	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.124228	1,064,768	132,274	54.00
60.00	06000 LABORATORY	0.117537	1,303,099	153,162	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.184745	350,456	64,745	65.00
66.00	06600 PHYSICAL THERAPY	0.606046	192,141	116,446	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.246890	118,902	29,356	67.00
68.00	06800 SPEECH PATHOLOGY	0.473259	22,092	10,455	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.249040	232,246	57,839	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.234257	422,013	98,859	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.193974	1,100,693	213,506	73.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.424477	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.301270	0	0	90.00
91.00	09100 EMERGENCY	0.093712	1,158,603	108,575	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.559016	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		6,510,216	1,032,010	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		6,510,216		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/18/2023 11:36 am
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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		282,011		30.00
43.00	04300 NURSERY		55,450		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.085826	370,053	31,760	50.00
50.01	05001 OPERATING ROOM	0.000000	0	0	50.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.326772	140,631	45,954	52.00
53.00	05300 ANESTHESIOLOGY	0.427878	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.124228	47,918	5,953	54.00
60.00	06000 LABORATORY	0.117537	138,717	16,304	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.184745	32,082	5,927	65.00
66.00	06600 PHYSICAL THERAPY	0.606046	14,231	8,625	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.246890	7,095	1,752	67.00
68.00	06800 SPEECH PATHOLOGY	0.473259	972	460	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.249040	31,445	7,831	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.234257	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.193974	139,188	26,999	73.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.424477	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.301270	0	0	90.00
91.00	09100 EMERGENCY	0.093712	85,859	8,046	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.559016	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,008,191	159,611	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)		1,008,191		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/18/2023 11:36 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		1,322,259	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		750,271	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		0	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		30.68	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
5.01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)		0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)		0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)		0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.90	30.00
31.00	Percentage of Medicaid patient days (see instructions)		27.46	31.00
32.00	Sum of lines 30 and 31		30.36	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00	33.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/18/2023 11:36 am	
		Title XVIII	Hospital	PPS	
				1.00	
34.00	Disproportionate share adjustment (see instructions)			62,176	34.00
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
Uncompensated Care Payment Adjustment					
35.00	Total uncompensated care amount (see instructions)		7,186,531,199	6,874,063,173	35.00
35.01	Factor 3 (see instructions)		0.000086318	0.000095135	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)		620,327	653,964	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)		463,970	164,835	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		628,805		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		2,763,511		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			2,763,511	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			156,569	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
55.01	Cellular therapy acquisition cost (see instructions)			0	55.01
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			2,920,080	59.00
60.00	Primary payer payments			1,437	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			2,918,643	61.00
62.00	Deductibles billed to program beneficiaries			362,169	62.00
63.00	Coinurance billed to program beneficiaries			0	63.00
64.00	Allowable bad debts (see instructions)			14,792	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			9,615	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			7,149	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			2,566,089	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)			0	70.75
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			0	70.93
70.94	HRR adjustment amount (see instructions)			0	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/18/2023 11:36 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2022	284,487	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2023	138,955	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		18,999	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		2,970,532	71.00
71.01	Sequestration adjustment (see instructions)		37,428	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM or CHART pass-throughs		0	71.03
72.00	Interim payments		2,706,294	72.00
72.01	Interim payments-PARHM or CHART		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM or CHART (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		226,810	74.00
74.01	Balance due provider/program-PARHM or CHART (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		80,974	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/18/2023 11:36 am
		Title XVIII	Hospital	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 OPPTS (see instructions)		3,758,567	2.00
3.00	OPPS payments		3,527,726	3.00
4.00	Outlier payment (see instructions)		5,235	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.859	5.00
6.00	Line 2 times line 5		3,228,609	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)		3,532,961	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		710,372	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)		2,822,589	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)		2,822,589	30.00
31.00	Primary payer payments		773	31.00
32.00	Subtotal (line 30 minus line 31)		2,821,816	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)		49,358	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		32,083	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		33,987	36.00
37.00	Subtotal (see instructions)		2,853,899	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
39.75	N95 respirator payment adjustment amount (see instructions)		0	39.75
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,853,899	40.00
40.01	Sequestration adjustment (see instructions)		35,959	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs		0	40.03
41.00	Interim payments		2,784,912	41.00
41.01	Interim payments-PARHM or CHART		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		33,028	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: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/18/2023 11:36 am
		Title XVIII	Hospital PPS
			1.00
200.00	MEDI CARE PART B ANCI LLARY COSTS Part B Combi ned Bi lled Days		0 200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0091

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

Worksheet E-1
Part I
Date/Time Prepared:
5/18/2023 11:36 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,706,294		2,784,912	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,706,294		2,784,912	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		226,810		33,028	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,933,104		2,817,940	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: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/18/2023 11:36 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (see instructions)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (see instructions)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPSS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet E-5 Date/Time Prepared: 5/18/2023 11:36 am
Title XVIII			PPS	
			1.00	
TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	1.00
2.00	Capital outlier from Wkst. L, Pt. 1, line 2		0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)		0	4.00
5.00	The rate used to calculate the time value of money (see instructions)		0.00	5.00
6.00	Time value of money for operating expenses (see instructions)		0	6.00
7.00	Time value of money for capital related expenses (see instructions)		0	7.00

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

Provider CCN: 15-0091

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

Worksheet G
Date/Time Prepared:
5/18/2023 11:36 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	2,324	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	24,671,619	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-15,934,143	0	0	0	6.00
7.00	Inventory	420,816	0	0	0	7.00
8.00	Prepaid expenses	-10,534	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	19,698,023	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	28,848,105	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	645,981	0	0	0	13.00
14.00	Accumulated depreciation	-526,425	0	0	0	14.00
15.00	Buildings	10,173,038	0	0	0	15.00
16.00	Accumulated depreciation	-3,270,576	0	0	0	16.00
17.00	Leasehold improvements	1,457,481	0	0	0	17.00
18.00	Accumulated depreciation	-921,247	0	0	0	18.00
19.00	Fixed equipment	336,828	0	0	0	19.00
20.00	Accumulated depreciation	-269,901	0	0	0	20.00
21.00	Automobiles and trucks	1,273,427	0	0	0	21.00
22.00	Accumulated depreciation	-1,081,266	0	0	0	22.00
23.00	Major movable equipment	13,125,445	0	0	0	23.00
24.00	Accumulated depreciation	-10,823,615	0	0	0	24.00
25.00	Minor equipment depreciable	2,075,082	0	0	0	25.00
26.00	Accumulated depreciation	-1,093,008	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	70,904	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	11,172,148	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	44,214,026	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	253,692	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	44,467,718	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	84,487,971	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,252,984	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,039,707	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	192,590	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	2,932,763	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,418,044	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	334,155	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	334,155	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,752,199	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	78,735,772				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)	78,735,772	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	84,487,971	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0091

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

Worksheet G-1

Date/Time Prepared:
5/18/2023 11:36 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		81,778,681		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-3,613,831				2.00
3.00	Total (sum of line 1 and line 2)		78,164,850		0		3.00
4.00	NONALLOWABLE HOME OFFICE INTEREST EX	570,922		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)		570,922		0		10.00
11.00	Subtotal (line 3 plus line 10)		78,735,772		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		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)		78,735,772		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	NONALLOWABLE HOME OFFICE INTEREST EX		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			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: 15-0091

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/18/2023 11:36 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	9,886,445		9,886,445	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	9,886,445		9,886,445	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				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)	9,886,445		9,886,445	17.00
18.00	Ancillary services	35,409,903	0	35,409,903	18.00
19.00	Outpatient services	0	185,720,673	185,720,673	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	22,574,685	22,574,685	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)	45,296,348	208,295,358	253,591,706	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		64,887,630		29.00
30.00	PROVISION FOR B/D	3,657,555			30.00
31.00	HOME OFFICE INTEREST EXPENSE	570,922			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)		4,228,477		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)		69,116,107		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0091

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

Worksheet G-3

Date/Time Prepared:
5/18/2023 11:36 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	253,591,706	1.00
2.00	Less contractual allowances and discounts on patients' accounts	184,333,880	2.00
3.00	Net patient revenues (line 1 minus line 2)	69,257,826	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	69,116,107	4.00
5.00	Net income from service to patients (line 3 minus line 4)	141,719	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-5,616,409	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	305,459	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	EMS SUBSIDY	474,470	24.00
24.01	OTHER OPERATING REVENUE	1,080,930	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	-3,755,550	25.00
26.00	Total (line 5 plus line 25)	-3,613,831	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)	-3,613,831	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0091	Period: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III Date/Time Prepared: 5/18/2023 11:36 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		154,726	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		1,843	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		11.79	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		156,569	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00