

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: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/31/2023 11:28 am
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**PART I - COST REPORT STATUS**

Provider use only

1.  Electronically prepared cost report  
 2.  Manually prepared cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

5.  Cost Report Status  
 (1) As Submitted  
 (2) Settled without Audit  
 (3) Settled with Audit  
 (4) Reopened  
 (5) Amended

6. Date Received:  
7. Contractor No.

8.  Initial Report for this Provider CCN  
 9.  Final Report for this Provider CCN

10. NPR Date:  
11. Contractor's Vendor Code: 4  
 12.  If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 5/31/2023 Time: 11:28 am

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL OF SOUTH BEND, INC ( 15-0058 ) 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			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00	HOSPITAL	0	494,580	-91,966	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	2.00
3.00	SUBPROVIDER - IRF	0	37,131	0	0	3.00
5.00	SWING BED - SNF	0	0	0	0	5.00
6.00	SWING BED - NF	0			0	6.00
200.00	TOTAL	0	531,711	-91,966	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-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/31/2023 11:28 am				
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 615 N MICHIGAN ST			PO Box:						1.00	
2.00	City: SOUTH BEND			State: IN		Zip Code: 46601		County: ST. JOSEPH		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		MEMORIAL HOSPITAL OF SOUTH BEND, INC	150058	43780	1	01/01/1984	N	P	P	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF		REHABILITATION UNIT	15T058	43780	5	01/01/1984	N	P	P	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)				Y	Y				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)				N	N	N			22.03	
22.04	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
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)										22.04
22.04	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0058			Period: From 01/01/2022 To 12/31/2022		Worksheet S-2 Part I Date/Time Prepared: 5/31/2023 11:28 am		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	5,920	11,194	931	1,993	20,243	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	34	373	0	24	770		25.00	
						Urban/Rural	S	Date of Geogr	
						1.00		2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:		Ending:	
						1.00		2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N		Y/N	
						1.00		2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
						V	XVII	XIX	
						1.00	2.00	3.00	
<b>Prospective Payment System (PPS)-Capital</b>									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)					N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR 412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
<b>Teaching Hospitals</b>									
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 impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					Y	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.					Y			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00

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			V	XVIII	XIX		
			1.00	2.00	3.00		
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.	Y	N		60.00		
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01		
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	Y			3.00	3.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20	
						1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings				0.00	62.01	
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		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	

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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
<b>Inpatient Psychiatric Facility PPS</b>					
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)		N	N	0
<b>Inpatient Rehabilitation Facility PPS</b>					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		Y		75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)		N	N	0
			1.00		
<b>Long Term Care Hospital PPS</b>					
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
<b>TEFRA Providers</b>					
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.		N		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
			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
			V	XIX	
			1.00	2.00	
<b>Title V and XIX Services</b>					
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/31/2023 11:28 am	
		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. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
<b>Rural Providers</b>					
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	N	N	N
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00
				1.00	
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	
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
<b>Miscellaneous Cost Reporting Information</b>					
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: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/31/2023 11:28 am
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1,116,294	656,943	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
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
<b>Certified Transplant Center Information</b>				
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
<b>All Providers</b>				
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	15H013
		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: BEACON HEALTH SYSTEM	Contractor's Name: WI PHYS SVCS		Contractor's Number: 08001
142.00	Street: 615 N MICHIGAN ST	PO Box:		
143.00	City: SOUTH BEND	State: IN	Zip Code: 46601	
			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: 15-0058		Period: From 01/01/2022 To 12/31/2022		Worksheet S-2 Part I Date/Time Prepared: 5/31/2023 11:28 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
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						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	161.00	
1.00								
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	
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
Beginni ng      Endi ng								
1.00      2.00								
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00
1.00      2.00								
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0058		Period: From 01/01/2022 To 12/31/2022		Worksheet S-2 Part II Date/Time Prepared: 5/31/2023 11:28 am	
		Y/N	Date				
		1.00	2.00				
<b>PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE</b>							
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
<b>Financial Data and Reports</b>							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
<b>Approved Educational Activities</b>							
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.	Y					7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y					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.	Y					11.00
		Y/N					
		1.00					1.00
<b>Bad Debts</b>							
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
<b>Bed Complement</b>							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					Y	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
<b>PS&amp;R Data</b>							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/15/2023	Y	04/15/2023		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Y		Y			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/31/2023 11:28 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		
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>						
<b>Capital Related Cost</b>						
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N		27.00
<b>Interest Expense</b>						
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N		31.00
<b>Purchased Services</b>						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N		33.00
<b>Provider-Based Physicians</b>						
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N		35.00
			Y/N	Date		
			1.00	2.00		
<b>Home Office Costs</b>						
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		
<b>Cost Report Preparer Contact Information</b>						
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.	JEN		BREDEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	BEACON HEALTH SYSTEM				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	574-647-1144		JBREDEN@BEACONHEALTHSYSTEM.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/31/2023 11:28 am
		3.00		
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT ANALYST		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0058

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/31/2023 11:28 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	Title V
	Line No.				Visits / Trips	
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - STATISTICAL DATA</b>						
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	363	132,495	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)		363	132,495	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	36	13,140	0.00	0	8.00
8.01 NEONATAL INTENSIVE CARE UNIT	31.01	30	10,950	0.00	0	8.01
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)		429	156,585	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF	41.00	20	7,300		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		449				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)		9	3,285			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: 15-0058

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/31/2023 11:28 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents			
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
	6.00	7.00	8.00	9.00	10.00		
<b>PART I - STATISTICAL DATA</b>							
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)	20,560	4,338	88,099			1.00
2.00	HMO and other (see instructions)	22,101	34,287				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	1,167				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)	20,560	4,338	88,099			7.00
8.00	INTENSIVE CARE UNIT	1,758	90	7,146			8.00
8.01	NEONATAL INTENSIVE CARE UNIT	0	1,132	8,604			8.01
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		350	3,953			13.00
14.00	Total (see instructions)	22,318	5,910	107,802	27.25	2,298.97	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF	1,245	34	4,924	0.00	22.80	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)			380			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				27.25	2,321.77	27.00
28.00	Observation Bed Days		0	9,840			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	84	235			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: 15-0058

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/31/2023 11:28 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
<b>PART I - STATISTICAL DATA</b>							
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	3,915	580	19,390	1.00
2.00	HMO and other (see instructions)			3,265	5,754		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				79		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
8.01	NEONATAL INTENSIVE CARE UNIT						8.01
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	3,915	580	19,390	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF	0.00	0	117	3	376	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: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part II Date/Time Prepared: 5/31/2023 11:28 am
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	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	199,083,502	0	199,083,502	4,829,272.00	41.22
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		1,415,014	0	1,415,014	7,696.00	183.86
4.01	Physicians - Part A - Teaching		2,664,775	0	2,664,775	22,418.00	118.87
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FOHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	2,280,624	2,280,624	56,682.86	40.23
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		5,204,733	3,341	5,208,074	158,061.00	32.95
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		20,487,518	0	20,487,518	219,169.00	93.48
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		311,982	0	311,982	2,889.00	107.99
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		23,294,762	0	23,294,762	621,393.00	37.49
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		44,980,982	0	44,980,982		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,226,364	0	1,226,364		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		267,951	0	267,951		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FOHC)		0	0	0		
25.00	Interns & residents (in an approved program)		433,809	0	433,809		
25.50	Home office wage-related (core)		7,240,149	0	7,240,149		
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: 15-0058

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

Worksheet S-3  
Part II  
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	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)	0	0	0			25.53
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	73,355	0	73,355	2,080.00	35.27	26.00
27.00	Administrative & General	5,482,359	-223,503	5,258,856	256,502.00	20.50	27.00
28.00	Administrative & General under contract (see inst.)	3,728,298	0	3,728,298	37,557.00	99.27	28.00
29.00	Maintenance & Repairs	0	97,949	97,949	0.00	0.00	29.00
30.00	Operation of Plant	2,984,916	3,704	2,988,620	106,819.00	27.98	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	3,312,834	2,518	3,315,352	175,383.00	18.90	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	3,635,928	-1,511,721	2,124,207	105,333.00	20.17	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	0	1,514,949	1,514,949	75,248.00	20.13	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	4,061,723	5,508	4,067,231	115,844.00	35.11	38.00
39.00	Central Services and Supply	2,039,687	2,008	2,041,695	92,711.00	22.02	39.00
40.00	Pharmacy	7,727,455	-6,495,686	1,231,769	5,080.00	242.47	40.00
41.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	41.00
42.00	Social Service	2,574,109	2,256	2,576,365	77,730.00	33.15	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0058

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/31/2023 11:28 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	200,147,025	-2,280,624	197,866,401	4,787,728.14	41.33	1.00
2.00	Excluded area salaries (see instructions)	5,204,733	3,341	5,208,074	158,061.00	32.95	2.00
3.00	Subtotal salaries (line 1 minus line 2)	194,942,292	-2,283,965	192,658,327	4,629,667.14	41.61	3.00
4.00	Subtotal other wages & related costs (see inst.)	44,094,262	0	44,094,262	843,451.00	52.28	4.00
5.00	Subtotal wage-related costs (see inst.)	52,221,131	0	52,221,131	0.00	27.11	5.00
6.00	Total (sum of lines 3 thru 5)	291,257,685	-2,283,965	288,973,720	5,473,118.14	52.80	6.00
7.00	Total overhead cost (see instructions)	35,620,664	-6,602,018	29,018,646	1,050,287.00	27.63	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part IV Date/Time Prepared: 5/31/2023 11:28 am
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		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	6,250,059	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
<b>HEALTH AND INSURANCE COST</b>			
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)	24,613,630	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	321,058	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	130,406	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)	431,997	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	773,096	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	14,387,656	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	60	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
<b>OTHER</b>			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	1,055	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	46,909,017	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part V Date/Time Prepared: 5/31/2023 11:28 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	22,618,617	46,756,069	1.00
2.00	Hospital	22,618,617	46,756,069	2.00
3.00	SUBPROVIDER - IPF	0	0	3.00
4.00	SUBPROVIDER - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet S-10 Date/Time Prepared: 5/31/2023 11:28 am
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			1.00	
<b>Uncompensated and indigent care cost computation</b>				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.254005	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		147,917,295	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		32,634,566	5.00
6.00	Medicaid charges		452,497,477	6.00
7.00	Medicaid cost (line 1 times line 6)		114,936,622	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		5,652	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		1,436	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		1,436	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)		28,468	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		358,335	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		91,019	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)		62,551	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)		63,987	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)	28,890,849	438,370	29,329,219
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	7,338,420	438,370	7,776,790
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	7,338,420	438,370	7,776,790
			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)		18,344,321	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		208,642	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		320,987	27.01
28.00	Non-Medicare bad debt expense (see instructions)		18,023,334	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		4,690,362	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		12,467,152	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		12,531,139	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0058

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

Worksheet A  
Date/Time Prepared:  
5/31/2023 11:28 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		0	0	22,522,377	22,522,377 1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	10,731,473	10,731,473 2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0 3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	73,355	1,973,932	2,047,287	773,096	2,820,383 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,482,359	137,020,652	142,503,011	-33,208,418	109,294,593 5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	97,949	97,949 6.00
7.00	00700	OPERATION OF PLANT	2,984,916	9,514,692	12,499,608	-12,926	12,486,682 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,494,463	1,494,463	0	1,494,463 8.00
9.00	00900	HOUSEKEEPING	3,312,834	2,470,622	5,783,456	2,518	5,785,974 9.00
10.00	01000	DIETARY	3,635,928	3,285,968	6,921,896	-2,880,855	4,041,041 10.00
11.00	01100	CAFETERIA	0	0	0	2,884,083	2,884,083 11.00
13.00	01300	NURSING ADMINISTRATION	4,061,723	1,200,298	5,262,021	5,481	5,267,502 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,039,687	10,159,066	12,198,753	-623,570	11,575,183 14.00
15.00	01500	PHARMACY	7,727,455	39,259,657	46,987,112	-33,574,670	13,412,442 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0 16.00
17.00	01700	SOCIAL SERVICE	2,574,109	841,900	3,416,009	2,256	3,418,265 17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	2,280,624	2,280,624 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	4,911,296	2,025,128	6,936,424	-2,297,924	4,638,500 22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	114,303	48,581	162,884	72	162,956 23.00
23.01	02301	PARAMED ED	0	0	0	0	0 23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	56,548,405	27,957,799	84,506,204	-2,156,595	82,349,609 30.00
31.00	03100	INTENSIVE CARE UNIT	10,128,634	6,504,430	16,633,064	-302,613	16,330,451 31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	8,794,533	2,293,368	11,087,901	-686,798	10,401,103 31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0 40.00
41.00	04100	SUBPROVIDER - IRF	2,183,239	1,825,193	4,008,432	-2,482	4,005,950 41.00
43.00	04300	NURSERY	0	0	0	2,314,271	2,314,271 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	21,185,521	50,710,143	71,895,664	-33,553,261	38,342,403 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,093,352	3,600,200	10,693,552	-235,287	10,458,265 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,250,312	11,281,600	21,531,912	-5,930,019	15,601,893 54.00
57.00	05700	CT SCAN	1,348,624	998,386	2,347,010	-11,805	2,335,205 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	465,839	1,557,303	2,023,142	24	2,023,166 58.00
59.00	05900	CARDIAC CATHETERIZATION	2,134,246	10,431,525	12,565,771	-10,193,781	2,371,990 59.00
60.00	06000	LABORATORY	3,309,091	13,771,605	17,080,696	2,666	17,083,362 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	3,238,006	4,630,963	7,868,969	-851,028	7,017,941 65.00
66.00	06600	PHYSICAL THERAPY	3,205,921	1,234,106	4,440,027	-128,887	4,311,140 66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	1,025,180	322,621	1,347,801	-11,555	1,336,246 66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	493,909	117,962	611,871	203	612,074 66.10
67.00	06700	OCCUPATIONAL THERAPY	1,708,987	537,003	2,245,990	587	2,246,577 67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	294,266	72,833	367,099	191	367,290 67.10
68.00	06800	SPEECH PATHOLOGY	995,595	245,692	1,241,287	-221	1,241,066 68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	236,919	52,343	289,262	-1,101	288,161 68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	18,778,352	18,778,352 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	32,702,165	32,702,165 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	33,579,209	33,579,209 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.00	03020	CARDIOLOGY	1,943,566	1,153,620	3,097,186	-37,524	3,059,662 76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0 77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0 90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	797,102	294,479	1,091,581	596	1,092,177 90.30
90.50	09004	SLEEP DISORDERS CLINIC	556,762	278,058	834,820	-815	834,005 90.50
91.00	09100	EMERGENCY	21,320,337	18,305,456	39,625,793	-73,040	39,552,753 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0 102.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0 113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	196,176,311	367,471,647	563,647,958	-96,982	563,550,976 118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
193.00	19300	NONPAID WORKERS	275,468	177,133	452,601	298	452,899 193.00
193.10	19301	HEALTH PROPERTIES	2,418,163	3,142,604	5,560,767	96,318	5,657,085 193.10
193.40	19303	LEIGHTON CENTER	0	0	0	0	0 193.40
193.50	19305	WELLNESS CENTER	0	115,352	115,352	0	115,352 193.50
193.80	19308	UNUSED SPACE	0	0	0	0	0 193.80
193.90	19309	OCCUPATIONAL HEALTH	0	0	0	0	0 193.90

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 15-0058		Period: From 01/01/2022 To 12/31/2022		Worksheet A Date/Time Prepared: 5/31/2023 11:28 am	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
193.91	19310	RESEARCH AND PROTOCOL	0	0	0	0	0	193.91
193.92	19311	CCOP	0	0	0	0	0	193.92
193.93	19312	RESEARCH ADMIN	213,560	48,011	261,571	366	261,937	193.93
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	199,083,502	370,954,747	570,038,249	0	570,038,249	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0058

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

Worksheet A  
Date/Time Prepared:  
5/31/2023 11:28 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-3,765,829	18,756,548	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	3,861,473	14,592,946	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,075	2,819,308	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-33,454,229	75,840,364	5.00
6.00	00600	MAINTENANCE & REPAIRS	-2,808	95,141	6.00
7.00	00700	OPERATION OF PLANT	-609,683	11,876,999	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,494,463	8.00
9.00	00900	HOUSEKEEPING	0	5,785,974	9.00
10.00	01000	DIETARY	-217,904	3,823,137	10.00
11.00	01100	CAFETERIA	-1,843,235	1,040,848	11.00
13.00	01300	NURSING ADMINISTRATION	-10,491	5,257,011	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-65,606	11,509,577	14.00
15.00	01500	PHARMACY	-3,535	13,408,907	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,418,265	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	2,280,624	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	4,638,500	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	-15,725	147,231	23.00
23.01	02301	PARAMED ED	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-265,201	82,084,408	30.00
31.00	03100	INTENSIVE CARE UNIT	-1,092,580	15,237,871	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	-161,795	10,239,308	31.01
40.00	04000	SUBPROVIDER - I PF	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	4,005,950	41.00
43.00	04300	NURSERY	0	2,314,271	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-2,514,601	35,827,802	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-1,853,717	8,604,548	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-330,896	15,270,997	54.00
57.00	05700	CT SCAN	-61,376	2,273,829	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-468,475	1,554,691	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,371,990	59.00
60.00	06000	LABORATORY	0	17,083,362	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	35	7,017,976	65.00
66.00	06600	PHYSICAL THERAPY	-165,283	4,145,857	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	-22,409	1,313,837	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	612,074	66.10
67.00	06700	OCCUPATIONAL THERAPY	-195,025	2,051,552	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	367,290	67.10
68.00	06800	SPEECH PATHOLOGY	0	1,241,066	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0	288,161	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18,778,352	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32,702,165	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-338,705	33,240,504	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03020	CARDIOLOGY	-12,150	3,047,512	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0	1,092,177	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	834,005	90.50
91.00	09100	EMERGENCY	-5,215,081	34,337,672	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-48,825,906	514,725,070	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
193.00	19300	NONPAID WORKERS	0	452,899	193.00
193.10	19301	HEALTH PROPERTIES	0	5,657,085	193.10
193.40	19303	LEIGHTON CENTER	0	0	193.40
193.50	19305	WELLNESS CENTER	0	115,352	193.50
193.80	19308	UNUSED SPACE	0	0	193.80
193.90	19309	OCCUPATIONAL HEALTH	0	0	193.90
193.91	19310	RESEARCH AND PROTOCOL	0	0	193.91
193.92	19311	CCOP	0	0	193.92



RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0058

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

Worksheet A  
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5/31/2023 11:28 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
193.93	19312	RESEARCH ADMIN	0	261,937	193.93
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-48,825,906	521,212,343	200.00

RECLASSIFICATIONS

Provider CCN: 15-0058

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

Worksheet A-6

Date/Time Prepared:  
5/31/2023 11:28 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
<b>A - DRUGS CHARGED TO PATIENTS</b>						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	27,078,517	1.00	
	TOTALS		0	27,078,517		
<b>B - SUPPLIES CHARGED TO PATIENTS</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	51,480,517	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
	O		0	51,480,517		
<b>C - AMORTIZATION TO CAPITAL</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	781,459	1.00	
	O		0	781,459		
<b>D - INTEREST TO CAPITAL</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	5,005,844	1.00	
	O		0	5,005,844		
<b>H - UTILIZATION OF H&amp;L</b>						
1.00		0.00	0	0	1.00	
	O		0	0		
<b>M - NICU</b>						
1.00	ADULTS & PEDIATRICS	30.00	533,402	139,344	1.00	
	TOTALS		533,402	139,344		
<b>N - RECLASS NURSERY FROM MATERNITY/LDR</b>						
1.00	NURSERY	43.00	1,843,507	470,764	1.00	
	O		1,843,507	470,764		
<b>O - CAFETERIA FROM DIET SALARIES</b>						
1.00	CAFETERIA	11.00	1,514,949	0	1.00	
	O		1,514,949	0		
<b>R - REBATES</b>						
1.00		0.00	0	0	1.00	
	O		0	0		
<b>W - WORKERS COMP EH&amp;W</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	773,096	1.00	
	O		0	773,096		
<b>X - PROPERTY INSURANCE TO CAPITAL</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	387,282	1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	61,538	2.00	
	O		0	448,820		
<b>Y - GARAGE TO A&amp;G</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	117,542	1.00	
	O		0	117,542		
<b>Z - INCENTIVE</b>						
1.00		0.00	0	0	1.00	
2.00	MAINTENANCE & REPAIRS	6.00	97,949	0	2.00	
3.00	OPERATION OF PLANT	7.00	3,704	0	3.00	
4.00	HOUSEKEEPING	9.00	2,518	0	4.00	
5.00	DIETARY	10.00	3,228	0	5.00	
6.00	NURSING ADMINISTRATION	13.00	5,508	0	6.00	
7.00	CENTRAL SERVICES & SUPPLY	14.00	2,008	0	7.00	
8.00	PHARMACY	15.00	5,006	0	8.00	
9.00	SOCIAL SERVICE	17.00	2,256	0	9.00	
10.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	15,482	0	10.00	

RECLASSIFICATIONS

Provider CCN: 15-0058

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

Worksheet A-6

Date/Time Prepared:  
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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
11.00	PARAMED ED PRGM-(SPECIFY)	23.00	72	0	11.00
12.00	ADULTS & PEDIATRICS	30.00	27,170	0	12.00
13.00	INTENSIVE CARE UNIT	31.00	3,951	0	13.00
14.00	NEONATAL INTENSIVE CARE UNIT	31.01	2,855	0	14.00
15.00	SUBPROVIDER - IRF	41.00	1,221	0	15.00
16.00	OPERATING ROOM	50.00	9,878	0	16.00
17.00	DELIVERY ROOM & LABOR ROOM	52.00	2,356	0	17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	11,166	0	18.00
19.00	CT SCAN	57.00	573	0	19.00
20.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	24	0	20.00
21.00	CARDIAC CATHETERIZATION	59.00	537	0	21.00
22.00	LABORATORY	60.00	2,666	0	22.00
23.00	RESPIRATORY THERAPY	65.00	1,824	0	23.00
24.00	PHYSICAL THERAPY	66.00	3,208	0	24.00
25.00	PHYSICAL THERAPY EAST BANK	66.01	561	0	25.00
26.00	PHYSICAL THERAPY LIVING CENTER	66.10	203	0	26.00
27.00	OCCUPATIONAL THERAPY	67.00	835	0	27.00
28.00	OCCUPATIONAL THERAPY LIVING CENTER	67.10	191	0	28.00
29.00	SPEECH PATHOLOGY	68.00	501	0	29.00
30.00	SPEECH THERAPY LIVING CENTER	68.10	143	0	30.00
31.00	CARDIOLOGY	76.00	3,205	0	31.00
32.00	HEMATOLOGY ONCOLOGY CLINIC	90.30	644	0	32.00
33.00	SLEEP DISORDERS CLINIC	90.50	310	0	33.00
34.00	EMERGENCY	91.00	9,702	0	34.00
35.00	NONPAID WORKERS	193.00	298	0	35.00
36.00	HEALTH PROPERTIES	193.10	1,384	0	36.00
37.00	RESEARCH ADMIN	193.93	366	0	37.00
			223,503	0	
AB - DEPRECIATION TO CAPITAL					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	16,631,735	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	9,438,417	2.00
			0	26,070,152	
BA - IMPLANTS CHARGED TO PATIENTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	32,702,165	1.00
			0	32,702,165	
DA - DACC TP CAPITAL					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,234,611	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	4,218	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
			0	1,238,829	
DD - INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	5,005,844	1.00
			0	5,005,844	
IR - INTERNS SALARY FROM LN 22 TO LN 21					
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	2,280,624	0	1.00
			2,280,624	0	
OO - CAFETERIA FROM DIET NON-SALARIES					
1.00	CAFETERIA	11.00	0	1,369,134	1.00
			0	1,369,134	

Provider CCN: 15-0058

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

Worksheet A-6  
Date/Time Prepared:  
5/31/2023 11:28 am

		Increases				
Cost Center		Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
PH - PHARMACY						
1.00	DRUGS CHARGED TO PATIENTS	73.00	6,500,692	0	1.00	
	0		6,500,692	0		
YY - PROPERTIES						
1.00	HEALTH PROPERTIES	193.10	0	283,943	1.00	
	0		0	283,943		
500.00	Grand Total: Increases		12,896,677	152,965,970	500.00	

RECLASSIFICATIONS

Provider CCN: 15-0058

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

Worksheet A-6  
Date/Time Prepared:  
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		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
<b>A - DRUGS CHARGED TO PATIENTS</b>							
1.00	PHARMACY	15.00	0	27,078,517	0		1.00
	TOTALS		0	27,078,517			
<b>B - SUPPLIES CHARGED TO PATIENTS</b>							
1.00	NURSING ADMINISTRATION	13.00	0	27	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	629,796	0		2.00
3.00	PHARMACY	15.00	0	467	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	485,070	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	304,217	0		5.00
6.00	NEONATAL INTENSIVE CARE UNIT	31.01	0	16,907	0		6.00
8.00	SUBPROVIDER - IRF	41.00	0	1,341	0		8.00
9.00	OPERATING ROOM	50.00	0	32,792,345	0		9.00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	0	237,643	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,941,185	0		11.00
12.00	CT SCAN	57.00	0	12,378	0		12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	10,173,609	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	803,405	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	33,457	0		15.00
16.00	PHYSICAL THERAPY EAST BANK	66.01	0	12,116	0		16.00
17.00	OCCUPATIONAL THERAPY	67.00	0	248	0		17.00
18.00	SPEECH PATHOLOGY	68.00	0	722	0		18.00
19.00	SPEECH THERAPY LIVING CENTER	68.10	0	1,244	0		19.00
20.00	CARDIOLOGY	76.00	0	764	0		20.00
21.00	HEMATOLOGY ONCOLOGY CLINIC	90.30	0	48	0		21.00
22.00	EMERGENCY	91.00	0	33,528	0		22.00
	O		0	51,480,517			
<b>C - AMORTIZATION TO CAPITAL</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	781,459	11		1.00
	O		0	781,459			
<b>D - INTEREST TO CAPITAL</b>							
1.00	INTEREST EXPENSE	113.00	0	5,005,844	11		1.00
	O		0	5,005,844			
<b>H - EE UTILIZATION OF H&amp;L</b>							
1.00		0.00	0	0	0		1.00
	O		0	0			
<b>M - NICU</b>							
1.00	NEONATAL INTENSIVE CARE UNIT	31.01	533,402	139,344	0		1.00
	TOTALS		533,402	139,344			
<b>N - RECLASS NURSERY FROM MATERNITY/LDR</b>							
1.00	ADULTS & PEDIATRICS	30.00	1,843,507	470,764	0		1.00
	O		1,843,507	470,764			
<b>O - CAFETERIA FROM DIET SALARIES</b>							
1.00	DIETARY	10.00	1,514,949	0	0		1.00
	O		1,514,949	0			
<b>R - REBATES</b>							
1.00		0.00	0	0	0		1.00
	O		0	0			
<b>W - WORKERS COMP EH&amp;W</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	773,096	0		1.00
	O		0	773,096			
<b>X - PROPERTY INSURANCE TO CAPITAL</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	448,820	12		1.00
2.00		0.00	0	0	12		2.00
	O		0	448,820			
<b>Y - GARAGE TO A&amp;G</b>							
1.00	HEALTH PROPERTIES	193.10	0	117,542	0		1.00
	O		0	117,542			
<b>Z - INCENTIVE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	223,503	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00

RECLASSIFICATIONS

Provider CCN: 15-0058

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

Worksheet A-6

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		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
17.00		0.00	0	0	0	0	17.00	
18.00		0.00	0	0	0	0	18.00	
19.00		0.00	0	0	0	0	19.00	
20.00		0.00	0	0	0	0	20.00	
21.00		0.00	0	0	0	0	21.00	
22.00		0.00	0	0	0	0	22.00	
23.00		0.00	0	0	0	0	23.00	
24.00		0.00	0	0	0	0	24.00	
25.00		0.00	0	0	0	0	25.00	
26.00		0.00	0	0	0	0	26.00	
27.00		0.00	0	0	0	0	27.00	
28.00		0.00	0	0	0	0	28.00	
29.00		0.00	0	0	0	0	29.00	
30.00		0.00	0	0	0	0	30.00	
31.00		0.00	0	0	0	0	31.00	
32.00		0.00	0	0	0	0	32.00	
33.00		0.00	0	0	0	0	33.00	
34.00		0.00	0	0	0	0	34.00	
35.00		0.00	0	0	0	0	35.00	
36.00		0.00	0	0	0	0	36.00	
37.00		0.00	0	0	0	0	37.00	
0			223,503	0				
<b>AB - DEPRECIATION TO CAPITAL</b>								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	26,070,152	9		1.00	
2.00		0.00	0	0	9		2.00	
0			0	26,070,152				
<b>BA - IMPLANTS CHARGED TO PATIENTS</b>								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	32,702,165	0		1.00	
0			0	32,702,165				
<b>DA - DACC TP CAPITAL</b>								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	23,086	10		1.00	
2.00	OPERATION OF PLANT	7.00	0	16,630	10		2.00	
3.00		0.00	0	0	10		3.00	
4.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	3,093	10		4.00	
5.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	32,782	10		5.00	
6.00	ADULTS & PEDIATRICS	30.00	0	57,170	10		6.00	
7.00	INTENSIVE CARE UNIT	31.00	0	2,347	10		7.00	
8.00	SUBPROVIDER - IRF	41.00	0	2,362	10		8.00	
9.00	OPERATING ROOM	50.00	0	770,794	10		9.00	
10.00		0.00	0	0	10		10.00	
11.00	CARDIAC CATHETERIZATION	59.00	0	20,709	10		11.00	
12.00		0.00	0	0	10		12.00	
13.00	RESPIRATORY THERAPY	65.00	0	49,447	10		13.00	
14.00	PHYSICAL THERAPY	66.00	0	98,638	10		14.00	
15.00	CARDIOLOGY	76.00	0	39,965	10		15.00	
16.00	SLEEP DISORDERS CLINIC	90.50	0	1,125	10		16.00	
17.00	EMERGENCY	91.00	0	49,214	10		17.00	
18.00	HEALTH PROPERTIES	193.10	0	71,467	10		18.00	
19.00		0.00	0	0	10		19.00	
0			0	1,238,829				
<b>DD - INTEREST EXPENSE</b>								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,005,844	0		1.00	
0			0	5,005,844				
<b>IR - INTERNS SALARY FROM LN 22 TO LN 21</b>								
1.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	2,280,624	0	0		1.00	
0			2,280,624	0				
<b>OO - CAFETERIA FROM DIET NON-SALARIES</b>								
1.00	DIETARY	10.00	0	1,369,134	0		1.00	
0			0	1,369,134				
<b>PH - PHARMACY</b>								
1.00	PHARMACY	15.00	6,500,692	0	0		1.00	
0			6,500,692	0				
<b>YY - PROPERTIES</b>								
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	283,943	14		1.00	
0			0	283,943				
500.00	Grand Total: Decreases		12,896,677	152,965,970			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0058

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
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		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	3.00	4.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	26,898,864	367,885	0	367,885	284,988	1.00
2.00	Land Improvements	4,737,942	561,842	0	561,842	0	2.00
3.00	Buildings and Fixtures	514,439,487	14,441,410	0	14,441,410	4,964,980	3.00
4.00	Building Improvements	324,743	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	242,951,369	12,512,987	0	12,512,987	453,973	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	789,352,405	27,884,124	0	27,884,124	5,703,941	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	789,352,405	27,884,124	0	27,884,124	5,703,941	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	26,981,761	435,320				1.00
2.00	Land Improvements	5,299,784	2,786,878				2.00
3.00	Buildings and Fixtures	523,915,917	156,322,129				3.00
4.00	Building Improvements	324,743	295,663				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	255,010,383	172,211,860				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	811,532,588	332,051,850				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	811,532,588	332,051,850				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0058

Period:  
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To 12/31/2022

Worksheet A-7  
Part II  
Date/Time Prepared:  
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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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	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	NEW CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00



RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0058

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

Worksheet A-7  
Part III  
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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	NEW CAP REL COSTS-BLDG & FIXT	556,562,785	0	556,562,785	0.689201	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	255,199,072	4,214,554	250,984,518	0.310799	0	2.00
3.00	Total (sum of lines 1-2)	811,761,857	4,214,554	807,547,303	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col.s. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	13,537,266	992,192	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	9,438,417	6,175,202	2.00
3.00	Total (sum of lines 1-2)	0	0	0	22,975,683	7,167,394	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 col.s. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	5,787,303	387,282	0	-1,947,495	18,756,548	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-792,723	61,538	0	-289,488	14,592,946	2.00
3.00	Total (sum of lines 1-2)	4,994,580	448,820	0	-2,236,983	33,349,494	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0058

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

Worksheet A-8

Date/Time Prepared:  
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst.	A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)		0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00		0	7.00
8.00 Television and radio service (chapter 21)		0		0.00		0	8.00
9.00 Parking lot (chapter 21)		0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-11,161,780				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	1,854,191				0	12.00
13.00 Laundry and linen service		0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-1,376,101	CAFETERIA	11.00		0	14.00
15.00 Rental of quarters to employee and others		0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00		0	16.00
17.00 Sale of drugs to other than patients		0		0.00		0	17.00
18.00 Sale of medical records and abstracts		0		0.00		0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00		0	19.00
19.01 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00		0	19.01
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		RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist			*** Cost Center Deleted ***	19.00		0	28.00
29.00 Physicians' assistant				0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			ADULTS & PEDIATRICS	30.00			30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0058

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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.
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	0	SPEECH PATHOLOGY	68.00		31.00			
32.00	CAH HIT Adjustment for Depreciation and Interest		0	0		0.00	0	32.00			
33.00	PENSION ADJUSTMENT	A	0	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00			
33.01	OTHER REVENUE - MED STAFF OFFICE	B	-33,406	5	ADMINISTRATIVE & GENERAL	5.00	0	33.01			
33.02	MEDICAL OVERFLOW	B	0	30	ADULTS & PEDIATRICS	30.00	0	33.02			
33.03	TAXABLE SALES - SUBWAY CAFETERIA	B	-467,134	11	CAFETERIA	11.00	0	33.03			
33.04	OTHER REVENUE - CBU	B	-5,775	52	DELIVERY ROOM & LABOR ROOM	52.00	0	33.04			
33.05	TAXABLE SALES - FCMC	B	-263,143	30	ADULTS & PEDIATRICS	30.00	0	33.05			
33.06	OTHER REVENUE - OTHER ADMIN	B	541	5	ADMINISTRATIVE & GENERAL	5.00	0	33.06			
33.07	OTHER REVENUE - BCC	B	-138	54	RADIOLOGY-DIAGNOSTIC	54.00	0	33.07			
33.08	OTHER REVENUE - CARD NSG ADMIN	B	0	76	CARDIOLOGY	76.00	0	33.08			
33.09	QUALITY INCENTIVE	B	-919,693	5	ADMINISTRATIVE & GENERAL	5.00	0	33.09			
33.10	CONTRACTED SERVICES	B	0	5	ADMINISTRATIVE & GENERAL	5.00	0	33.10			
33.11	INTEREST INCOME - WORKING CAPITAL	B	-49,482	2	NEW CAP REL COSTS-MVBLE EQUIP	2.00	11	33.11			
33.12	PRIVATE LABEL PBM RXM REVENUE	B	-3,535	15	PHARMACY	15.00	0	33.12			
33.13	OTHER REVENUE - MATERNAL CHILD SUPPO	B	70	30	ADULTS & PEDIATRICS	30.00	0	33.13			
33.14	OTHER REVENUE - BIOMED	B	0	6	MAINTENANCE & REPAIRS	6.00	0	33.14			
33.15	PROGRAM MEAL OFFSET	B	-188,466	10	DIETARY	10.00	0	33.15			
33.16	VISITOR MEAL OFFSET	B	0	11	CAFETERIA	11.00	0	33.16			
33.17	OTHER REVENUE - ENGINEERING	B	0	7	OPERATION OF PLANT	7.00	0	33.17			
33.18	OTHER REVENUE - LAB	B	0	91	EMERGENCY	91.00	0	33.18			
33.19	ENVIRONMENTAL SERVICES	B	0	9	HOUSEKEEPING	9.00	0	33.19			
33.20	OTHER REVENUE - EMPLOYEE BENEFITS	B	0	4	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20			
33.22	OTHER REVENUE - RADIOLOGY DIAGN	B	0	54	RADIOLOGY-DIAGNOSTIC	54.00	0	33.22			
33.23	UR AND SOCIAL SERVICES PSYCH	B	0	40	SUBPROVIDER - IPF	40.00	0	33.23			
33.24	OTHER REVENUE - NICU	B	-165	31	NEONATAL INTENSIVE CARE UNIT	31.01	0	33.24			
33.25	OTHER REVENUE-MRI	B	-468,475	58	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	33.25			
33.26	OTHER REVENUE - NEONATAL SERVICES	B	-1,330	31	NEONATAL INTENSIVE CARE UNIT	31.01	0	33.26			
33.27	OTHER REVENUE - GROUND TRANSPORT	B	-8,665	91	EMERGENCY	91.00	0	33.27			
33.28	INTEREST INCOME - WORKING CAPITAL	A	0	1	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.28			
33.30	OTHER REVENUE - DRIVER'S EDUCATION	B	0	67	OCCUPATIONAL THERAPY	67.00	0	33.30			
33.33	OTHER REVENUE - RAD ADMIN	B	0	54	RADIOLOGY-DIAGNOSTIC	54.00	0	33.33			
33.35	NONALLOWABLE CAPITALIZED INTERE	A	-13,123	1	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.35			
33.36	OTHER REVENUE - MAIN STREET PT	B	0	66	PHYSICAL THERAPY	66.00	0	33.36			
33.39	PACE COMPONENT DEPREC 29 V 23 Y	A	0	1	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.39			
33.42	EXCESS CAPITALIZED INTEREST PAC	A	-9,762	1	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.42			
33.46	ALLOWABLE CAPITALIZED INTEREST	A	10,626	1	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.46			
33.48	NONALLOWABLE CAPITALIZED INTERE	A	-3,092	1	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.48			
33.50	INCORRECT LIFING ON ASBESTOS AN	A	0	1	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.50			
33.55	OTHER REVENUE - RENT	B	-990,589	1	NEW CAP REL COSTS-BLDG & FIXT	1.00	14	33.55			
33.57	MEMBERSHIP REVENUE	B	0	5	ADMINISTRATIVE & GENERAL	5.00	0	33.57			
33.58	SPECIAL PROGRAM REVENUE	B	0	5	ADMINISTRATIVE & GENERAL	5.00	0	33.58			
33.59	SEMINAR REVENUE	B	-1,075	4	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.59			
33.63	STERILIZATION REVENUE	B	0	52	DELIVERY ROOM & LABOR ROOM	52.00	0	33.63			
33.66	OTHER REVENUE - NUTRITIONAL SER	B	-29,438	10	DIETARY	10.00	0	33.66			
33.76	OTHER REVENUE - CATH LAB	B	0	59	CARDIAC CATHETERIZATION	59.00	0	33.76			
33.88	OTHER REVENUE - SBSC PT	B	-165,283	66	PHYSICAL THERAPY	66.00	0	33.88			
33.94	EDUC SERVICES EMS	B	-15,725	23	PARAMED ED PRGM-(SPECIFY)	23.00	0	33.94			

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
				Cost Center	Line #	
				1.00	2.00	
33.96	PARKING GARAGE - OPERATING	A	-67,026	ADMINISTRATIVE & GENERAL	5.00	0 33.96
33.97	PARKING GARAGE - CAPITAL	A	-53,971	NEW CAP REL COSTS-BLDG & FIXT	1.00	10 33.97
34.03	NON ALLOWABLE 1999 INTEREST	A	-743,241	NEW CAP REL COSTS-MVBLE EQUIP	2.00	11 34.03
34.23	ADMISSION REVENUE	B	0	ADMINISTRATIVE & GENERAL	5.00	0 34.23
34.31	SKYWAY INTEREST AMORTIZATION	A	3,580	NEW CAP REL COSTS-BLDG & FIXT	1.00	10 34.31
34.36	OLD CAPITAL - BUILDING	A	32,782	NEW CAP REL COSTS-BLDG & FIXT	1.00	14 34.36
34.37	NEW CAPITAL BUILDING	A	-5,543	NEW CAP REL COSTS-BLDG & FIXT	1.00	14 34.37
35.02	OTHER REVENUE - AMBULANCE SUPPL	B	-65,606	CENTRAL SERVICES & SUPPLY	14.00	0 35.02
36.01	LOBBY EXPENSE	A	0	ADMINISTRATIVE & GENERAL	5.00	0 36.01
36.05	HAF EXPENSE	A	-27,477,288	ADMINISTRATIVE & GENERAL	5.00	0 36.05
36.18	TRUSTEE FEES	A	-20,530	ADMINISTRATIVE & GENERAL	5.00	0 36.18
36.23	CONTRIBUTIONS	A	-757,700	ADMINISTRATIVE & GENERAL	5.00	0 36.23
36.25	NON-ALLOWED EXPENSES	A	0	ADMINISTRATIVE & GENERAL	5.00	0 36.25
36.26	ENTRY FEES	B	0	ADMINISTRATIVE & GENERAL	5.00	0 36.26
37.00	OTHER REVENUE - MATERNAL CHILD ADMIN	B	-380	ADULTS & PEDIATRICS	30.00	0 37.00
37.01	OTHER REVENUE - OSTC	B	-10,491	NURSING ADMINISTRATIVE	13.00	0 37.01
37.03	OTHER REV - TRAUMA SVCS	B	-26,894	EMERGENCY	91.00	0 37.03
39.00	OTHER REVENUE - TEAM PHARMACY	B	-283,546	DRUGS CHARGED TO PATIENTS	73.00	0 39.00
40.00	OTHER REVENUE - PEDS REHAB OT	B	-195,025	OCCUPATIONAL THERAPY	67.00	0 40.00
41.00	OTHER REVENUE - FCMC	B	-1,748	ADULTS & PEDIATRICS	30.00	0 41.00
42.00	OTHER REVENUE - PULMONARY MED/SURG	B	0	ADULTS & PEDIATRICS	30.00	0 42.00
44.00	OTHER REVENUE - CARDIAC REHAB	B	0	CARDIOLOGY	76.00	0 44.00
44.01	OTHER REVENUE - OSTC	B	-22,409	PHYSICAL THERAPY EAST BANK	66.01	0 44.01
44.02	OTHER REVENUE - SAFETY	B	0	NURSING ADMINISTRATIVE	13.00	0 44.02
44.03	OTHER REVENUE - 11 SOUTH	B	0	ADULTS & PEDIATRICS	30.00	0 44.03
44.04	OTHER REVENUE - 12 SOUTH	B	0	ADULTS & PEDIATRICS	30.00	0 44.04
44.05	OTHER REVENUE - SOCIAL SERVICES	B	0	SOCIAL SERVICE	17.00	0 44.05
44.06	OTHER REVENUE - PHARMACY	B	-55,159	DRUGS CHARGED TO PATIENTS	73.00	0 44.06
44.07	PULMONARY	B	35	RESPIRATORY THERAPY	65.00	0 44.07
44.08	OTHER REVENUE - GRANGER ADMIN	B	0	ADMINISTRATIVE & GENERAL	5.00	0 44.08
44.09	OTHER REVENUE - INDEPENDENT CARE	B	0	SOCIAL SERVICE	17.00	0 44.09
44.10	OTHER REVENUE - ORNISH CARDIAC REHAB	B	0	CARDIOLOGY	76.00	0 44.10
44.11	OTHER REVENUE - RES SVCS	B	0	NURSING ADMINISTRATIVE	13.00	0 44.11
44.12	OTHER REVENUE - 8 SOUTH	B	0	ADULTS & PEDIATRICS	30.00	0 44.12
44.13	OTHER REVENUE - SOCIAL SVCS	B	0	SOCIAL SERVICE	17.00	0 44.13
44.14	BREMEN SALARIES TO HOME OFFICE	A	0	0	0.00	0 44.14
44.15	OTHER REVENUE - NSG FLOATS	B	0	NURSING ADMINISTRATIVE	13.00	0 44.15
44.16	OTHER REVENUE - ER	B	-37,367	EMERGENCY	91.00	0 44.16
44.17	OTHER REVENUE - EPWORTH ADULT ACUTE	B	0	ADULTS & PEDIATRICS	30.00	0 44.17
44.18	OTHER REVENUE - ENVIRONMENTAL PSYCH	B	0	HOUSEKEEPING	9.00	0 44.18
44.19	OTHER REVENUE - HEART VASCULAR	B	0	CARDIOLOGY	76.00	0 44.19
44.20	OTHER REVENUE - GIFT SHOP	B	-31,700	ADMINISTRATIVE & GENERAL	5.00	0 44.20
44.21	OTHER REVENUE - GROUNDS	B	0	OPERATION OF PLANT	7.00	0 44.21
44.22	HOME OFFICE ADJUSTMENT	A	-274,131	NEW CAP REL COSTS-BLDG & FIXT	1.00	9 44.22
44.23	BUILDING TO HOME OFFICE	A	-700,202	NEW CAP REL COSTS-BLDG & FIXT	1.00	14 44.23
44.24	MME TO HOME OFFICE	A	-289,488	NEW CAP REL COSTS-MVBLE EQUIP	2.00	14 44.24
44.25	MAINTENANCE TO HOME OFFICE	A	-2,808	MAINTENANCE & REPAIRS	6.00	0 44.25
44.26	PLANT TO HOME OFFICE	A	-609,683	OPERATION OF PLANT	7.00	14 44.26
44.27	OTHER REVENUE-AQUATICS CENTER	B	0	OCCUPATIONAL THERAPY	67.00	0 44.27
44.28	OTHER REVENUE-SURGERY	B	0	OPERATING ROOM	50.00	0 44.28
44.29	OTHER REVENUE-SURGERY ADMIN	B	0	OPERATING ROOM	50.00	0 44.29
44.30	AFFLIATE RENT	B	-2,820,338	NEW CAP REL COSTS-BLDG & FIXT	1.00	9 44.30
44.31	OTHER REVENUE-PICU	B	0	INTENSIVE CARE UNIT	31.00	0 44.31
44.32	OTHER REVENUE-GH EMERGENCY	B	-82	EMERGENCY	91.00	0 44.32

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0058

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

Worksheet A-8

Date/Time Prepared:  
5/31/2023 11:28 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
	1.00	2.00	3.00	4.00	5.00	
44.33 OTHER REVENUE-COMMUNITY HEALTH	B		ADMINISTRATIVE & GENERAL	5.00	0	44.33
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-48,825,906				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: 15-0058  
 Period: From 01/01/2022 To 12/31/2022  
 Worksheet A-8-1  
 Date/Time Prepared: 5/31/2023 11:28 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	1.00	NEW CAP REL COSTS-BLDG & FIX	1,057,934	0	1.00
2.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	4,943,684	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	63,475,119	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	0	67,622,546	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		69,476,737	67,622,546	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	100.00	BEACON HLTH SYS	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: 15-0058

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

Worksheet A-8-1

Date/Time Prepared:  
5/31/2023 11:28 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	1,057,934	10		1.00
2.00	4,943,684	10		2.00
3.00	63,475,119	0		3.00
4.00	-67,622,546	0		4.00
5.00	1,854,191			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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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: 15-0058

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

Worksheet A-8-2

Date/Time Prepared:  
5/31/2023 11:28 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	31.00	INTENSIVE CARE UNIT	1,092,580	1,092,580	0	0	0	1.00
2.00	31.01	NEONATAL INTENSIVE CARE UNIT	160,300	160,300	0	0	0	2.00
3.00	50.00	OPERATING ROOM	2,514,601	2,514,601	0	0	0	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	1,847,942	1,847,942	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	330,758	330,758	0	0	0	5.00
6.00	57.00	CT SCAN	61,376	61,376	0	0	0	6.00
7.00	76.00	CARDIOLOGY	12,150	12,150	0	0	0	7.00
8.00	91.00	EMERGENCY	5,142,073	5,142,073	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			11,161,780	11,161,780	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	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	1.00
2.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	57.00	CT SCAN	0	0	0	0	0	6.00
7.00	76.00	CARDIOLOGY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	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	31.00	INTENSIVE CARE UNIT	0	0	0	1,092,580	1.00
2.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	160,300	2.00
3.00	50.00	OPERATING ROOM	0	0	0	2,514,601	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	1,847,942	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	330,758	5.00
6.00	57.00	CT SCAN	0	0	0	61,376	6.00
7.00	76.00	CARDIOLOGY	0	0	0	12,150	7.00
8.00	91.00	EMERGENCY	0	0	0	5,142,073	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	11,161,780	200.00



COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0058

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/31/2023 11:28 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	18,756,548	18,756,548			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	14,592,946		14,592,946		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,819,308	0	0	2,819,308	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	75,840,364	815,643	634,585	74,502	77,365,094
6.00 00600	MAINTENANCE & REPAIRS	95,141	53,052	41,275	1,388	190,856
7.00 00700	OPERATION OF PLANT	11,876,999	3,125,936	2,432,037	42,340	17,477,312
8.00 00800	LAUNDRY & LINEN SERVICE	1,494,463	2,963	2,305	0	1,499,731
9.00 00900	HOUSEKEEPING	5,785,974	373,303	290,437	46,969	6,496,683
10.00 01000	DIETARY	3,823,137	476,372	370,627	30,094	4,700,230
11.00 01100	CAFETERIA	1,040,848	83,349	64,847	21,462	1,210,506
13.00 01300	NURSING ADMINISTRATION	5,257,011	202,474	157,529	57,620	5,674,634
14.00 01400	CENTRAL SERVICES & SUPPLY	11,509,577	609,307	474,053	28,925	12,621,862
15.00 01500	PHARMACY	13,408,907	297,515	231,472	17,450	13,955,344
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
17.00 01700	SOCIAL SERVICE	3,418,265	106,679	82,998	36,499	3,644,441
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,280,624	0	0	32,310	2,312,934
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	4,638,500	287,063	223,340	37,488	5,186,391
23.00 02300	PARAMED ED PRGM-(SPECIFY)	147,231	0	0	1,620	148,851
23.01 02301	PARAMED ED	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	82,084,408	4,218,082	3,281,747	782,876	90,367,113
31.00 03100	INTENSIVE CARE UNIT	15,237,871	521,109	405,433	143,548	16,307,961
31.01 02060	NEONATAL INTENSIVE CARE UNIT	10,239,308	504,030	392,145	117,076	11,252,559
40.00 04000	SUBPROVIDER - I PF	0	0	0	0	0
41.00 04100	SUBPROVIDER - I RF	4,005,950	186,975	145,470	30,947	4,369,342
43.00 04300	NURSERY	2,314,271	75,717	58,909	26,117	2,475,014
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	35,827,802	1,885,788	1,467,178	300,275	39,481,043
52.00 05200	DELIVERY ROOM & LABOR ROOM	8,604,548	547,024	425,595	100,525	9,677,692
54.00 05400	RADIOLOGY-DIAGNOSTIC	15,270,997	1,241,549	965,948	145,374	17,623,868
57.00 05700	CT SCAN	2,273,829	45,006	35,016	19,114	2,372,965
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,554,691	67,779	52,733	6,600	1,681,803
59.00 05900	CARDIAC CATHETERIZATION	2,371,990	251,790	195,898	30,243	2,849,921
60.00 06000	LABORATORY	17,083,362	182,144	141,711	46,918	17,454,135
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	7,017,976	116,520	90,655	45,899	7,271,050
66.00 06600	PHYSICAL THERAPY	4,145,857	208,706	162,377	45,464	4,562,404
66.01 06602	PHYSICAL THERAPY EAST BANK	1,313,837	0	0	14,532	1,328,369
66.10 06601	PHYSICAL THERAPY LIVING CENTER	612,074	0	0	7,000	619,074
67.00 06700	OCCUPATIONAL THERAPY	2,051,552	29,489	22,943	24,223	2,128,207
67.10 06701	OCCUPATIONAL THERAPY LIVING CENTER	367,290	0	0	4,172	371,462
68.00 06800	SPEECH PATHOLOGY	1,241,066	6,286	4,890	14,112	1,266,354
68.10 06801	SPEECH THERAPY LIVING CENTER	288,161	0	0	3,358	291,519
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,778,352	0	0	0	18,778,352
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	32,702,165	0	0	0	32,702,165
73.00 07300	DRUGS CHARGED TO PATIENTS	33,240,504	0	0	92,095	33,332,599
74.00 07400	RENAL DIALYSIS	0	0	0	0	0
76.00 03020	CARDIOLOGY	3,047,512	51,184	39,822	27,580	3,166,098
77.00 07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	0
90.10 09001	FAMILY PRACTICE CLINIC	0	0	0	0	0
90.30 09002	HEMATOLOGY ONCOLOGY CLINIC	1,092,177	286,649	223,019	11,302	1,613,147
90.50 09004	SLEEP DISORDERS CLINIC	834,005	48,867	38,020	7,892	928,784
91.00 09100	EMERGENCY	34,337,672	1,374,538	1,069,416	302,183	37,083,809
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	514,725,070	18,282,888	14,224,430	2,778,092	513,841,678
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	85,505	66,524	0	152,029
193.00 19300	NONPAID WORKERS	452,899	65,731	51,140	3,907	573,677
193.10 19301	HEALTH PROPERTIES	5,657,085	202,689	157,696	34,278	6,051,748
193.40 19303	LEIGHTON CENTER	0	113,180	88,056	0	201,236
193.50 19305	WELLNESS CENTER	115,352	0	0	0	115,352

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0058

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

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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
193.80 19308 UNUSED SPACE	0	0	0	0	0	193.80
193.90 19309 OCCUPATIONAL HEALTH	0	0	0	0	0	193.90
193.91 19310 RESEARCH AND PROTOCOL	0	0	0	0	0	193.91
193.92 19311 CCOP	0	0	0	0	0	193.92
193.93 19312 RESEARCH ADMIN	261,937	6,555	5,100	3,031	276,623	193.93
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	521,212,343	18,756,548	14,592,946	2,819,308	521,212,343	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Prepared: 5/31/2023 11:28 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		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT				1.00		
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00		
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00		
5.00 00500	ADMINISTRATIVE & GENERAL	77,365,094			5.00		
6.00 00600	MAINTENANCE & REPAIRS	33,267	224,123		6.00		
7.00 00700	OPERATION OF PLANT	3,046,400	39,166	20,562,878	7.00		
8.00 00800	LAUNDRY & LINEN SERVICE	261,412	37	4,128	1,765,308	8.00	
9.00 00900	HOUSEKEEPING	1,132,411	4,677	520,000	0	8,153,771	9.00
10.00 01000	DIETARY	819,278	5,969	663,571	0	418,935	10.00
11.00 01100	CAFETERIA	210,998	1,044	116,103	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	989,123	2,537	282,040	0	8,120	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,200,066	7,634	848,746	0	122,782	14.00
15.00 01500	PHARMACY	2,432,500	3,728	414,429	0	20,870	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	635,248	1,337	148,600	0	10,557	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	403,158	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	904,019	3,597	399,869	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	25,946	0	0	0	0	23.00
23.01 02301	PARAMED ED	0	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	15,751,386	52,848	5,875,649	707,721	4,369,952	30.00
31.00 03100	INTENSIVE CARE UNIT	2,842,575	6,529	725,888	49,153	27,610	31.00
31.01 02060	NEONATAL INTENSIVE CARE UNIT	1,961,389	6,315	702,097	43,019	609,036	31.01
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	761,603	2,343	260,450	47,703	264,890	41.00
43.00 04300	NURSERY	431,410	949	105,471	26,433	101,668	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	6,881,783	23,628	2,626,841	371,578	817,732	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,686,880	6,854	761,987	137,749	368,345	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,071,946	15,556	1,729,438	0	434,202	54.00
57.00 05700	CT SCAN	413,622	564	62,692	108,400	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	293,148	849	94,413	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	496,758	3,155	350,736	0	84,453	59.00
60.00 06000	LABORATORY	3,042,360	2,282	253,721	0	62,690	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	1,267,388	1,460	162,309	0	12,830	65.00
66.00 06600	PHYSICAL THERAPY	795,254	2,615	290,721	0	45,881	66.00
66.01 06602	PHYSICAL THERAPY EAST BANK	231,543	0	0	0	0	66.01
66.10 06601	PHYSICAL THERAPY LIVING CENTER	107,908	0	0	0	0	66.10
67.00 06700	OCCUPATIONAL THERAPY	370,959	369	41,078	0	9,501	67.00
67.10 06701	OCCUPATIONAL THERAPY LIVING CENTER	64,748	0	0	0	0	67.10
68.00 06800	SPEECH PATHOLOGY	220,733	79	8,756	0	1,868	68.00
68.10 06801	SPEECH THERAPY LIVING CENTER	50,814	0	0	0	0	68.10
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,273,179	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	5,700,184	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	5,810,072	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03020	CARDIOLOGY	551,870	641	71,298	0	0	76.00
77.00 07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000	CLINIC	0	0	0	0	0	90.00
90.10 09001	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.10
90.30 09002	HEMATOLOGY ONCOLOGY CLINIC	281,181	3,592	399,294	0	0	90.30
90.50 09004	SLEEP DISORDERS CLINIC	161,893	612	68,071	0	0	90.50
91.00 09100	EMERGENCY	6,463,930	17,222	1,914,688	273,552	348,937	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	76,080,342	218,188	19,903,084	1,765,308	8,140,859	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	26,500	1,071	119,105	0	0	190.00
193.00 19300	NONPAID WORKERS	99,995	824	91,562	0	10,557	193.00
193.10 19301	HEALTH PROPERTIES	1,054,856	2,540	282,340	0	0	193.10
193.40 19303	LEIGHTON CENTER	35,077	1,418	157,656	0	0	193.40
193.50 19305	WELLNESS CENTER	20,107	0	0	0	0	193.50
193.80 19308	UNUSED SPACE	0	0	0	0	0	193.80
193.90 19309	OCCUPATIONAL HEALTH	0	0	0	0	0	193.90
193.91 19310	RESEARCH AND PROTOCOL	0	0	0	0	0	193.91
193.92 19311	CCOP	0	0	0	0	0	193.92
193.93 19312	RESEARCH ADMIN	48,217	82	9,131	0	2,355	193.93

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0058

Period:  
From 01/01/2022  
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	77,365,094	224,123	20,562,878	1,765,308	8,153,771	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0058

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

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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	6,607,983					10.00
11.00	01100	0	1,538,651				11.00
13.00	01300	0	45,196	7,001,650			13.00
14.00	01400	0	36,180	0	15,837,270		14.00
15.00	01500	0	64,073	659	0	16,891,603	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	19,456	14,073	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	35,487	0	0	0	22.00
23.00	02300	0	1,299	50	0	0	23.00
23.01	02301	0	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	5,418,294	458,756	3,044,960	0	6,921	30.00
31.00	03100	735,837	76,088	673,130	0	0	31.00
31.01	02060	0	60,532	545,739	0	2,761	31.01
40.00	04000	0	0	0	0	0	40.00
41.00	04100	366,651	18,368	116,094	0	0	41.00
43.00	04300	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	163,020	937,641	0	135	50.00
52.00	05200	87,201	48,425	443,513	0	531	52.00
54.00	05400	0	96,050	122,621	0	1,431	54.00
57.00	05700	0	12,422	0	0	0	57.00
58.00	05800	0	4,345	7,861	0	0	58.00
59.00	05900	0	13,886	47,370	0	1,571	59.00
60.00	06000	0	46,081	34	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	29,219	0	0	1,300	65.00
66.00	06600	0	30,285	16,321	0	0	66.00
66.01	06602	0	11,624	0	0	0	66.01
66.10	06601	0	4,770	0	0	0	66.10
67.00	06700	0	17,369	0	0	0	67.00
67.10	06701	0	3,244	0	0	0	67.10
68.00	06800	0	9,829	0	0	5	68.00
68.10	06801	0	2,209	0	0	0	68.10
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	9,660,735	0	71.00
72.00	07200	0	0	0	6,176,535	0	72.00
73.00	07300	0	0	0	0	16,864,105	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03020	0	16,843	53,913	0	577	76.00
77.00	07700	0	0	0	0	0	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
90.10	09001	0	0	0	0	0	90.10
90.30	09002	0	8,585	66,875	0	0	90.30
90.50	09004	0	6,486	0	0	0	90.50
91.00	09100	0	156,881	903,393	0	12,266	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
102.00	10200	0	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	0	0	0	0	0	113.00
118.00		6,607,983	1,497,008	6,994,247	15,837,270	16,891,603	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
193.00	19300	0	3,815	59	0	0	193.00
193.10	19301	0	35,772	3,049	0	0	193.10
193.40	19303	0	0	0	0	0	193.40
193.50	19305	0	0	0	0	0	193.50
193.80	19308	0	0	0	0	0	193.80
193.90	19309	0	0	0	0	0	193.90
193.91	19310	0	0	0	0	0	193.91
193.92	19311	0	0	0	0	0	193.92

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0058

Period:  
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
193.93	19312 RESEARCH ADMIN	0	2,056	4,295	0	0	193.93
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	6,607,983	1,538,651	7,001,650	15,837,270	16,891,603	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0058

Period:  
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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED PRGM	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			16.00	17.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW 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
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	0					16.00
17.00 01700 SOCIAL SERVICE	0	4,473,712				17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	2,716,092			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	6,529,363		22.00
23.00 02300 PARAMED PRGM-(SPECIFY)	0	0	0	0	176,146	23.00
23.01 02301 PARAMED	0	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	0	2,236,853	1,728,331	4,154,832	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	497,079	7,974	19,169	0	31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	0	248,540	0	0	0	31.01
40.00 04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - IRF	0	248,540	0	0	0	41.00
43.00 04300 NURSERY	0	248,540	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	248,540	99,673	239,610	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	248,540	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	248,540	4,984	11,980	0	54.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0	0	32,892	79,071	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01 06602 PHYSICAL THERAPY EAST BANK	0	0	0	0	0	66.01
66.10 06601 PHYSICAL THERAPY LIVING CENTER	0	0	0	0	0	66.10
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	0	67.10
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.10 06801 SPEECH THERAPY LIVING CENTER	0	0	0	0	0	68.10
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	14,951	35,941	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03020 CARDIOLOGY	0	0	72,761	174,915	0	76.00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.10 09001 FAMILY PRACTICE CLINIC	0	0	604,019	1,452,034	0	90.10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	0	0	0	90.30
90.50 09004 SLEEP DISORDERS CLINIC	0	0	0	0	0	90.50
91.00 09100 EMERGENCY	0	248,540	142,533	342,642	176,146	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	4,473,712	2,708,118	6,510,194	176,146	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
193.00 19300 NONPAID WORKERS	0	0	7,974	19,169	0	193.00
193.10 19301 HEALTH PROPERTIES	0	0	0	0	0	193.10
193.40 19303 LEIGHTON CENTER	0	0	0	0	0	193.40
193.50 19305 WELLNESS CENTER	0	0	0	0	0	193.50
193.80 19308 UNUSED SPACE	0	0	0	0	0	193.80
193.90 19309 OCCUPATIONAL HEALTH	0	0	0	0	0	193.90

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0058

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

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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED PRGM		
					SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
			16.00	17.00	21.00	22.00	23.00		
193.91	19310	RESEARCH AND PROTOCOL	0	0	0	0	0	0	193.91
193.92	19311	CCOP	0	0	0	0	0	0	193.92
193.93	19312	RESEARCH ADMIN	0	0	0	0	0	0	193.93
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments			0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,473,712	2,716,092	6,529,363	176,146	0	202.00



COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Prepared: 5/31/2023 11:28 am
Cost Center Description	PARAMED	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	23.01	24.00	25.00	26.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW 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
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
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD					22.00
23.00 02300	PARAMED PRGM-(SPECIFY)					23.00
23.01 02301	PARAMED ED	0				23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	134,173,616	-5,883,163	128,290,453	30.00
31.00 03100	INTENSIVE CARE UNIT	0	21,968,993	-27,143	21,941,850	31.00
31.01 02060	NEONATAL INTENSIVE CARE UNIT	0	15,431,987	0	15,431,987	31.01
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	0	6,455,984	0	6,455,984	41.00
43.00 04300	NURSERY	0	3,389,485	0	3,389,485	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	51,891,224	-339,283	51,551,941	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	13,467,717	0	13,467,717	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	23,360,616	-16,964	23,343,652	54.00
57.00 05700	CT SCAN	0	2,970,665	0	2,970,665	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,082,419	0	2,082,419	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	3,847,850	0	3,847,850	59.00
60.00 06000	LABORATORY	0	20,861,303	0	20,861,303	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	8,857,519	-111,963	8,745,556	65.00
66.00 06600	PHYSICAL THERAPY	0	5,743,481	0	5,743,481	66.00
66.01 06602	PHYSICAL THERAPY EAST BANK	0	1,571,536	0	1,571,536	66.01
66.10 06601	PHYSICAL THERAPY LIVING CENTER	0	731,752	0	731,752	66.10
67.00 06700	OCCUPATIONAL THERAPY	0	2,567,483	0	2,567,483	67.00
67.10 06701	OCCUPATIONAL THERAPY LIVING CENTER	0	439,454	0	439,454	67.10
68.00 06800	SPEECH PATHOLOGY	0	1,507,624	0	1,507,624	68.00
68.10 06801	SPEECH THERAPY LIVING CENTER	0	344,542	0	344,542	68.10
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	31,712,266	0	31,712,266	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	44,629,776	-50,892	44,578,884	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	56,006,776	0	56,006,776	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00 03020	CARDIOLOGY	0	4,108,916	-247,676	3,861,240	76.00
77.00 07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
90.10 09001	FAMILY PRACTICE CLINIC	0	2,056,053	-2,056,053	0	90.10
90.30 09002	HEMATOLOGY ONCOLOGY CLINIC	0	2,372,674	0	2,372,674	90.30
90.50 09004	SLEEP DISORDERS CLINIC	0	1,165,846	0	1,165,846	90.50
91.00 09100	EMERGENCY	0	48,084,539	-485,175	47,599,364	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	511,802,096	-9,218,312	502,583,784	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	298,705	0	298,705	190.00
193.00 19300	NONPAID WORKERS	0	807,632	-27,143	780,489	193.00
193.10 19301	HEALTH PROPERTIES	0	7,430,305	0	7,430,305	193.10
193.40 19303	LEIGHTON CENTER	0	395,387	0	395,387	193.40
193.50 19305	WELLNESS CENTER	0	135,459	0	135,459	193.50
193.80 19308	UNUSED SPACE	0	0	0	0	193.80
193.90 19309	OCCUPATIONAL HEALTH	0	0	0	0	193.90

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0058

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

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Cost Center Description			PARAMED ED	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.01	24.00	25.00	26.00	
193.91	19310	RESEARCH AND PROTOCOL	0	0	0	0	193.91
193.92	19311	CCOP	0	0	0	0	193.92
193.93	19312	RESEARCH ADMIN	0	342,759	0	342,759	193.93
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	521,212,343	-9,245,455	511,966,888	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0058

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

Worksheet B Part II Date/Time Prepared: 5/31/2023 11:28 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT
		NEW BLDG & FIXT	NEW MVBLE EQUIP		
		0	2.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	815,643	634,585	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	53,052	41,275	6.00
7.00 00700	OPERATION OF PLANT	0	3,125,936	2,432,037	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	2,963	2,305	8.00
9.00 00900	HOUSEKEEPING	0	373,303	290,437	9.00
10.00 01000	DIETARY	0	476,372	370,627	10.00
11.00 01100	CAFETERIA	0	83,349	64,847	11.00
13.00 01300	NURSING ADMINISTRATION	0	202,474	157,529	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	609,307	474,053	14.00
15.00 01500	PHARMACY	0	297,515	231,472	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	106,679	82,998	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	287,063	223,340	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	23.00
23.01 02301	PARAMED ED	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 03000	ADULTS & PEDIATRICS	0	4,218,082	3,281,747	30.00
31.00 03100	INTENSIVE CARE UNIT	0	521,109	405,433	31.00
31.01 02060	NEONATAL INTENSIVE CARE UNIT	0	504,030	392,145	31.01
40.00 04000	SUBPROVIDER - IPF	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	0	186,975	145,470	41.00
43.00 04300	NURSERY	0	75,717	58,909	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000	OPERATING ROOM	0	1,885,788	1,467,178	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	547,024	425,595	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	1,241,549	965,948	54.00
57.00 05700	CT SCAN	0	45,006	35,016	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	67,779	52,733	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	251,790	195,898	59.00
60.00 06000	LABORATORY	0	182,144	141,711	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	116,520	90,655	65.00
66.00 06600	PHYSICAL THERAPY	0	208,706	162,377	66.00
66.01 06602	PHYSICAL THERAPY EAST BANK	0	0	0	66.01
66.10 06601	PHYSICAL THERAPY LIVING CENTER	0	0	0	66.10
67.00 06700	OCCUPATIONAL THERAPY	0	29,489	22,943	67.00
67.10 06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	67.10
68.00 06800	SPEECH PATHOLOGY	0	6,286	4,890	68.00
68.10 06801	SPEECH THERAPY LIVING CENTER	0	0	0	68.10
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	74.00
76.00 03020	CARDIOLOGY	0	51,184	39,822	76.00
77.00 07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000	CLINIC	0	0	0	90.00
90.10 09001	FAMILY PRACTICE CLINIC	0	0	0	90.10
90.30 09002	HEMATOLOGY ONCOLOGY CLINIC	0	286,649	223,019	90.30
90.50 09004	SLEEP DISORDERS CLINIC	0	48,867	38,020	90.50
91.00 09100	EMERGENCY	0	1,374,538	1,069,416	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00 11300	INTEREST EXPENSE	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	18,282,888	14,224,430	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	85,505	66,524	190.00
193.00 19300	NONPAID WORKERS	0	65,731	51,140	193.00
193.10 19301	HEALTH PROPERTIES	0	202,689	157,696	193.10
193.40 19303	LEIGHTON CENTER	0	113,180	88,056	193.40
193.50 19305	WELLNESS CENTER	0	0	0	193.50
193.80 19308	UNUSED SPACE	0	0	0	193.80

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0058

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

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Part II  
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2.00			
193.90 19309 OCCUPATIONAL HEALTH	0	0	0	0	0	193.90
193.91 19310 RESEARCH AND PROTOCOL	0	0	0	0	0	193.91
193.92 19311 CCOP	0	0	0	0	0	193.92
193.93 19312 RESEARCH ADMIN	0	6,555	5,100	11,655	0	193.93
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	18,756,548	14,592,946	33,349,494		202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0058		Period: From 01/01/2022 To 12/31/2022		Worksheet B Part II Date/Time Prepared: 5/31/2023 11:28 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	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,450,228				5.00
6.00	00600	MAINTENANCE & REPAIRS	624	94,951			6.00
7.00	00700	OPERATION OF PLANT	57,098	16,593	5,631,664		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,900	16	1,130	11,314	8.00
9.00	00900	HOUSEKEEPING	21,225	1,982	142,415	0	829,362
10.00	01000	DIETARY	15,356	2,529	181,736	0	42,612
11.00	01100	CAFETERIA	3,955	442	31,798	0	0
13.00	01300	NURSING ADMINISTRATION	18,539	1,075	77,244	0	826
14.00	01400	CENTRAL SERVICES & SUPPLY	41,236	3,234	232,450	0	12,489
15.00	01500	PHARMACY	45,592	1,579	113,502	0	2,123
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
17.00	01700	SOCIAL SERVICE	11,906	566	40,698	0	1,074
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	7,556	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	16,944	1,524	109,514	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	486	0	0	0	0
23.01	02301	PARAMED ED	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	295,406	22,388	1,609,194	4,535	444,490
31.00	03100	INTENSIVE CARE UNIT	53,278	2,766	198,803	315	2,808
31.01	02060	NEONATAL INTENSIVE CARE UNIT	36,762	2,675	192,287	276	61,948
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	14,275	992	71,331	306	26,943
43.00	04300	NURSERY	8,086	402	28,886	169	10,341
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	128,985	10,010	719,427	2,382	83,176
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,617	2,904	208,690	883	37,466
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,577	6,590	473,650	0	44,165
57.00	05700	CT SCAN	7,752	239	17,170	695	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,494	360	25,858	0	0
59.00	05900	CARDIAC CATHETERIZATION	9,311	1,337	96,058	0	8,590
60.00	06000	LABORATORY	57,023	967	69,488	0	6,377
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	23,755	619	44,452	0	1,305
66.00	06600	PHYSICAL THERAPY	14,905	1,108	79,621	0	4,667
66.01	06602	PHYSICAL THERAPY EAST BANK	4,340	0	0	0	0
66.10	06601	PHYSICAL THERAPY LIVING CENTER	2,023	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	6,953	157	11,250	0	966
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	1,214	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	4,137	33	2,398	0	190
68.10	06801	SPEECH THERAPY LIVING CENTER	952	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	61,349	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	106,838	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	108,898	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03020	CARDIOLOGY	10,344	272	19,527	0	0
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	5,270	1,522	109,357	0	0
90.50	09004	SLEEP DISORDERS CLINIC	3,034	259	18,643	0	0
91.00	09100	EMERGENCY	121,153	7,296	524,386	1,753	35,492
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,426,148	92,436	5,450,963	11,314	828,048
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	497	454	32,620	0	0
193.00	19300	NONPAID WORKERS	1,874	349	25,076	0	1,074
193.10	19301	HEALTH PROPERTIES	19,771	1,076	77,326	0	0
193.40	19303	LEIGHTON CENTER	657	601	43,178	0	0
193.50	19305	WELLNESS CENTER	377	0	0	0	0
193.80	19308	UNUSED SPACE	0	0	0	0	0
193.90	19309	OCCUPATIONAL HEALTH	0	0	0	0	0
193.91	19310	RESEARCH AND PROTOCOL	0	0	0	0	0
193.92	19311	CCOP	0	0	0	0	0
193.93	19312	RESEARCH ADMIN	904	35	2,501	0	240

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0058		Period: From 01/01/2022 To 12/31/2022		Worksheet B Part II Date/Time Prepared: 5/31/2023 11:28 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	
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	1,450,228	94,951	5,631,664	11,314	829,362	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0058		Period: From 01/01/2022 To 12/31/2022		Worksheet B Part II Date/Time Prepared: 5/31/2023 11:28 am	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	1,089,232					10.00
11.00	01100	CAFETERIA	0	184,391				11.00
13.00	01300	NURSING ADMINISTRATION	0	5,416	463,103			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,336	0	1,377,105		14.00
15.00	01500	PHARMACY	0	7,678	44	0	699,505	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,332	931	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	4,253	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	156	3	0	0	23.00
23.01	02301	PARAMED ED	0	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	893,129	54,977	201,399	0	287	30.00
31.00	03100	INTENSIVE CARE UNIT	121,292	9,118	44,522	0	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	7,254	36,096	0	114	31.01
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	60,437	2,201	7,679	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	19,536	62,018	0	6	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,374	5,803	29,335	0	22	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,511	8,110	0	59	54.00
57.00	05700	CT SCAN	0	1,489	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	521	520	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,664	3,133	0	65	59.00
60.00	06000	LABORATORY	0	5,522	2	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	3,502	0	0	54	65.00
66.00	06600	PHYSICAL THERAPY	0	3,629	1,080	0	0	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0	1,393	0	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	572	0	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	0	2,082	0	0	0	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	389	0	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	0	1,178	0	0	0	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0	265	0	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	840,034	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	537,071	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	698,366	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	CARDIOLOGY	0	2,018	3,566	0	24	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0	1,029	4,423	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	777	0	0	0	90.50
91.00	09100	EMERGENCY	0	18,800	59,752	0	508	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,089,232	179,401	462,613	1,377,105	699,505	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
193.00	19300	NONPAID WORKERS	0	457	4	0	0	193.00
193.10	19301	HEALTH PROPERTIES	0	4,287	202	0	0	193.10
193.40	19303	LEIGHTON CENTER	0	0	0	0	0	193.40
193.50	19305	WELLNESS CENTER	0	0	0	0	0	193.50
193.80	19308	UNUSED SPACE	0	0	0	0	0	193.80
193.90	19309	OCCUPATIONAL HEALTH	0	0	0	0	0	193.90
193.91	19310	RESEARCH AND PROTOCOL	0	0	0	0	0	193.91
193.92	19311	CCOP	0	0	0	0	0	193.92

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prepared: 5/31/2023 11:28 am			
Cost Center Description		DI ETARY	CAFETERIA	NURSI NG ADM NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
193.93	19312 RESEARCH ADMIN	0	246	284	0	0	193.93
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	1,089,232	184,391	463,103	1,377,105	699,505	202.00



ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0058

Period:  
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To 12/31/2022

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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED PRGM	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			16.00	17.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW 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
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	0					16.00
17.00 01700 SOCIAL SERVICE	0	247,184				17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	7,556			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	642,638		22.00
23.00 02300 PARAMED PRGM-(SPECIFY)	0	0	0	0	645	23.00
23.01 02301 PARAMED PRGM	0	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	0	123,595				30.00
31.00 03100 INTENSIVE CARE UNIT	0	27,465				31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	0	13,732				31.01
40.00 04000 SUBPROVIDER - IPF	0	0				40.00
41.00 04100 SUBPROVIDER - IRF	0	13,732				41.00
43.00 04300 NURSERY	0	13,732				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	13,732				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	13,732				52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	13,732				54.00
57.00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0				59.00
60.00 06000 LABORATORY	0	0				60.00
60.01 06001 BLOOD LABORATORY	0	0				60.01
65.00 06500 RESPIRATORY THERAPY	0	0				65.00
66.00 06600 PHYSICAL THERAPY	0	0				66.00
66.01 06602 PHYSICAL THERAPY EAST BANK	0	0				66.01
66.10 06601 PHYSICAL THERAPY LIVING CENTER	0	0				66.10
67.00 06700 OCCUPATIONAL THERAPY	0	0				67.00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0				67.10
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
68.10 06801 SPEECH THERAPY LIVING CENTER	0	0				68.10
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
76.00 03020 CARDIOLOGY	0	0				76.00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0				77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0				90.00
90.10 09001 FAMILY PRACTICE CLINIC	0	0				90.10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	0				90.30
90.50 09004 SLEEP DISORDERS CLINIC	0	0				90.50
91.00 09100 EMERGENCY	0	13,732				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
102.00 10200 OPIOID TREATMENT PROGRAM	0	0				102.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)					0
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
193.00 19300 NONPAID WORKERS	0	0				193.00
193.10 19301 HEALTH PROPERTIES	0	0				193.10
193.40 19303 LEIGHTON CENTER	0	0				193.40
193.50 19305 WELLNESS CENTER	0	0				193.50
193.80 19308 UNUSED SPACE	0	0				193.80
193.90 19309 OCCUPATIONAL HEALTH	0	0				193.90

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0058

Period:  
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To 12/31/2022

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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED PRGM	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			16.00	17.00		
193.91 19310 RESEARCH AND PROTOCOL	0	0				193.91
193.92 19311 CCOP	0	0				193.92
193.93 19312 RESEARCH ADMIN	0	0				193.93
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0				194.00
200.00 Cross Foot Adjustments			7,556	642,638	645	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	247,184	7,556	642,638	645	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prepared: 5/31/2023 11:28 am
Cost Center	Description	PARAMED ED	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
		23.01	24.00	25.00	26.00
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW 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
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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			23.00
23.01	02301	PARAMED ED	0		23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	11,149,229	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,386,909	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	1,247,319	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	530,341	0	41.00
43.00	04300	NURSERY	196,242	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	4,392,238	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,317,445	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,822,891	0	54.00
57.00	05700	CT SCAN	107,367	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	153,265	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	567,846	0	59.00
60.00	06000	LABORATORY	463,234	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	280,862	0	65.00
66.00	06600	PHYSICAL THERAPY	476,093	0	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	5,733	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	2,595	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	73,840	0	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	1,603	0	67.10
68.00	06800	SPEECH PATHOLOGY	19,112	0	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	1,217	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	901,383	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	643,909	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	807,264	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03020	CARDIOLOGY	126,757	0	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	631,269	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	109,600	0	90.50
91.00	09100	EMERGENCY	3,226,826	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	31,642,389	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	185,600	0	190.00
193.00	19300	NONPAID WORKERS	145,705	0	193.00
193.10	19301	HEALTH PROPERTIES	463,047	0	193.10
193.40	19303	LEIGHTON CENTER	245,672	0	193.40
193.50	19305	WELLNESS CENTER	377	0	193.50
193.80	19308	UNUSED SPACE	0	0	193.80
193.90	19309	OCCUPATIONAL HEALTH	0	0	193.90

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0058

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Cost Center Description			PARAMED ED	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.01	24.00	25.00	26.00	
193.91	19310	RESEARCH AND PROTOCOL		0	0	0	193.91
193.92	19311	CCOP		0	0	0	193.92
193.93	19312	RESEARCH ADMIN		15,865	0	15,865	193.93
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS		0	0	0	194.00
200.00		Cross Foot Adjustments	0	650,839	0	650,839	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	33,349,494	0	33,349,494	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0058

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

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	1,044,388				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		1,044,388			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	199,010,147		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	45,416	45,416	5,258,856	-77,365,094	443,847,249
6.00 00600	MAINTENANCE & REPAIRS	2,954	2,954	97,949	0	190,856
7.00 00700	OPERATION OF PLANT	174,056	174,056	2,988,620	0	17,477,312
8.00 00800	LAUNDRY & LINEN SERVICE	165	165	0	0	1,499,731
9.00 00900	HOUSEKEEPING	20,786	20,786	3,315,352	0	6,496,683
10.00 01000	DIETARY	26,525	26,525	2,124,207	0	4,700,230
11.00 01100	CAFETERIA	4,641	4,641	1,514,949	0	1,210,506
13.00 01300	NURSING ADMINISTRATION	11,274	11,274	4,067,231	0	5,674,634
14.00 01400	CENTRAL SERVICES & SUPPLY	33,927	33,927	2,041,695	0	12,621,862
15.00 01500	PHARMACY	16,566	16,566	1,231,769	0	13,955,344
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
17.00 01700	SOCIAL SERVICE	5,940	5,940	2,576,365	0	3,644,441
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	2,280,624	0	2,312,934
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	15,984	15,984	2,646,154	0	5,186,391
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	114,375	0	148,851
23.01 02301	PARAMED ED	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	234,868	234,868	55,265,470	0	90,367,113
31.00 03100	INTENSIVE CARE UNIT	29,016	29,016	10,132,585	0	16,307,961
31.01 02060	NEONATAL INTENSIVE CARE UNIT	28,065	28,065	8,263,986	0	11,252,559
40.00 04000	SUBPROVIDER - I PF	0	0	0	0	0
41.00 04100	SUBPROVIDER - I RF	10,411	10,411	2,184,460	0	4,369,342
43.00 04300	NURSERY	4,216	4,216	1,843,507	0	2,475,014
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	105,003	105,003	21,195,399	0	39,481,043
52.00 05200	DELIVERY ROOM & LABOR ROOM	30,459	30,459	7,095,708	0	9,677,692
54.00 05400	RADIOLOGY-DIAGNOSTIC	69,131	69,131	10,261,478	0	17,623,868
57.00 05700	CT SCAN	2,506	2,506	1,349,197	0	2,372,965
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	3,774	3,774	465,863	0	1,681,803
59.00 05900	CARDIAC CATHETERIZATION	14,020	14,020	2,134,783	0	2,849,921
60.00 06000	LABORATORY	10,142	10,142	3,311,757	0	17,454,135
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	6,488	6,488	3,239,830	0	7,271,050
66.00 06600	PHYSICAL THERAPY	11,621	11,621	3,209,129	0	4,562,404
66.01 06602	PHYSICAL THERAPY EAST BANK	0	0	1,025,741	0	1,328,369
66.10 06601	PHYSICAL THERAPY LIVING CENTER	0	0	494,112	0	619,074
67.00 06700	OCCUPATIONAL THERAPY	1,642	1,642	1,709,822	0	2,128,207
67.10 06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0	294,457	0	371,462
68.00 06800	SPEECH PATHOLOGY	350	350	996,096	0	1,266,354
68.10 06801	SPEECH THERAPY LIVING CENTER	0	0	237,062	0	291,519
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	18,778,352
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	32,702,165
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	6,500,692	0	33,332,599
74.00 07400	RENAL DIALYSIS	0	0	0	0	0
76.00 03020	CARDIOLOGY	2,850	2,850	1,946,771	0	3,166,098
77.00 07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	0
90.10 09001	FAMILY PRACTICE CLINIC	0	0	0	0	0
90.30 09002	HEMATOLOGY ONCOLOGY CLINIC	15,961	15,961	797,746	0	1,613,147
90.50 09004	SLEEP DISORDERS CLINIC	2,721	2,721	557,072	0	928,784
91.00 09100	EMERGENCY	76,536	76,536	21,330,039	0	37,083,809
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,018,014	1,018,014	196,100,908	-77,365,094	436,476,584
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,761	4,761	0	0	152,029
193.00 19300	NONPAID WORKERS	3,660	3,660	275,766	0	573,677
193.10 19301	HEALTH PROPERTIES	11,286	11,286	2,419,547	0	6,051,748
193.40 19303	LEIGHTON CENTER	6,302	6,302	0	0	201,236
193.50 19305	WELLNESS CENTER	0	0	0	0	115,352

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0058

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

Worksheet B-1

Date/Time Prepared:  
5/31/2023 11:28 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
193.80 19308 UNUSED SPACE	0	0	0	0	0	0	193.80
193.90 19309 OCCUPATIONAL HEALTH	0	0	0	0	0	0	193.90
193.91 19310 RESEARCH AND PROTOCOL	0	0	0	0	0	0	193.91
193.92 19311 CCOP	0	0	0	0	0	0	193.92
193.93 19312 RESEARCH ADMIN	365	365	213,926	0	0	276,623	193.93
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	0	194.00
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)	18,756,548	14,592,946	2,819,308			77,365,094	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	17.959368	13.972725	0.014167			0.174306	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			0			1,450,228	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000000			0.003267	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: 15-0058

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

Worksheet B-1

Date/Time Prepared:  
5/31/2023 11:28 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW 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	996,018				6.00
7.00	00700	OPERATION OF PLANT	174,056	821,962			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	165	165	3,520,410		8.00
9.00	00900	HOUSEKEEPING	20,786	20,786	0	100,410	9.00
10.00	01000	DIETARY	26,525	26,525	0	5,159	469,145
11.00	01100	CAFETERIA	4,641	4,641	0	0	0
13.00	01300	NURSING ADMINISTRATION	11,274	11,274	0	100	0
14.00	01400	CENTRAL SERVICES & SUPPLY	33,927	33,927	0	1,512	0
15.00	01500	PHARMACY	16,566	16,566	0	257	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
17.00	01700	SOCIAL SERVICE	5,940	5,940	0	130	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	15,984	15,984	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
23.01	02301	PARAMED ED	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	234,868	234,868	1,411,349	53,814	384,681
31.00	03100	INTENSIVE CARE UNIT	29,016	29,016	98,022	340	52,242
31.01	02060	NEONATAL INTENSIVE CARE UNIT	28,065	28,065	85,790	7,500	0
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0
41.00	04100	SUBPROVIDER - I RF	10,411	10,411	95,130	3,262	26,031
43.00	04300	NURSERY	4,216	4,216	52,714	1,252	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	105,003	105,003	741,008	10,070	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	30,459	30,459	274,701	4,536	6,191
54.00	05400	RADIOLOGY-DIAGNOSTIC	69,131	69,131	0	5,347	0
57.00	05700	CT SCAN	2,506	2,506	216,174	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,774	3,774	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	14,020	14,020	0	1,040	0
60.00	06000	LABORATORY	10,142	10,142	0	772	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	6,488	6,488	0	158	0
66.00	06600	PHYSICAL THERAPY	11,621	11,621	0	565	0
66.01	06602	PHYSICAL THERAPY EAST BANK	0	0	0	0	0
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	1,642	1,642	0	117	0
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	350	350	0	23	0
68.10	06801	SPEECH THERAPY LIVING CENTER	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03020	CARDIOLOGY	2,850	2,850	0	0	0
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	15,961	15,961	0	0	0
90.50	09004	SLEEP DISORDERS CLINIC	2,721	2,721	0	0	0
91.00	09100	EMERGENCY	76,536	76,536	545,522	4,297	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	969,644	795,588	3,520,410	100,251	469,145
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,761	4,761	0	0	0
193.00	19300	NONPAID WORKERS	3,660	3,660	0	130	0
193.10	19301	HEALTH PROPERTIES	11,286	11,286	0	0	0
193.40	19303	LEIGHTON CENTER	6,302	6,302	0	0	0
193.50	19305	WELLNESS CENTER	0	0	0	0	0
193.80	19308	UNUSED SPACE	0	0	0	0	0
193.90	19309	OCCUPATIONAL HEALTH	0	0	0	0	0
193.91	19310	RESEARCH AND PROTOCOL	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0058

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

Worksheet B-1

Date/Time Prepared:  
5/31/2023 11:28 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
193.92	19311 CCOP	0	0	0	0	0	193.92
193.93	19312 RESEARCH ADMIN	365	365	0	29	0	193.93
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	224,123	20,562,878	1,765,308	8,153,771	6,607,983	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.225019	25.016823	0.501450	81.204770	14.085161	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	94,951	5,631,664	11,314	829,362	1,089,232	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.095331	6.851489	0.003214	8.259755	2.321738	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: 15-0058

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

Worksheet B-1  
Date/Time Prepared:  
5/31/2023 11:28 am

Cost Center Description		CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION  (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	4,110,160					11.00
13.00	01300	120,730	1,669,203				13.00
14.00	01400	96,646	0	100			14.00
15.00	01500	171,157	157	0	27,119,157		15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	51,972	3,355	0	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	94,795	0	0	0	0	22.00
23.00	02300	3,471	12	0	0	0	23.00
23.01	02301	0	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,225,471	725,923	0	11,112	0	30.00
31.00	03100	203,251	160,475	0	0	0	31.00
31.01	02060	161,697	130,105	0	4,432	0	31.01
40.00	04000	0	0	0	0	0	40.00
41.00	04100	49,066	27,677	0	0	0	41.00
43.00	04300	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	435,471	223,535	0	216	0	50.00
52.00	05200	129,356	105,734	0	853	0	52.00
54.00	05400	256,576	29,233	0	2,298	0	54.00
57.00	05700	33,183	0	0	0	0	57.00
58.00	05800	11,606	1,874	0	0	0	58.00
59.00	05900	37,092	11,293	0	2,522	0	59.00
60.00	06000	123,096	8	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	78,052	0	0	2,087	0	65.00
66.00	06600	80,899	3,891	0	0	0	66.00
66.01	06602	31,050	0	0	0	0	66.01
66.10	06601	12,743	0	0	0	0	66.10
67.00	06700	46,398	0	0	0	0	67.00
67.10	06701	8,665	0	0	0	0	67.10
68.00	06800	26,255	0	0	8	0	68.00
68.10	06801	5,900	0	0	0	0	68.10
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	61	0	0	71.00
72.00	07200	0	0	39	0	0	72.00
73.00	07300	0	0	0	27,075,010	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03020	44,991	12,853	0	926	0	76.00
77.00	07700	0	0	0	0	0	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
90.10	09001	0	0	0	0	0	90.10
90.30	09002	22,933	15,943	0	0	0	90.30
90.50	09004	17,327	0	0	0	0	90.50
91.00	09100	419,072	215,370	0	19,693	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
102.00	10200	0	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		3,998,921	1,667,438	100	27,119,157	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
193.00	19300	10,191	14	0	0	0	193.00
193.10	19301	95,556	727	0	0	0	193.10
193.40	19303	0	0	0	0	0	193.40
193.50	19305	0	0	0	0	0	193.50
193.80	19308	0	0	0	0	0	193.80
193.90	19309	0	0	0	0	0	193.90

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0058

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

Worksheet B-1

Date/Time Prepared:  
5/31/2023 11:28 am

Cost Center Description		CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION  (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
193.91	19310 RESEARCH AND PROTOCOL	0	0	0	0	0	193.91
193.92	19311 CCOP	0	0	0	0	0	193.92
193.93	19312 RESEARCH ADMIN	5,492	1,024	0	0	0	193.93
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	1,538,651	7,001,650	15,837,270	16,891,603	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.374353	4.194607	158,372.700000	0.622866	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	184,391	463,103	1,377,105	699,505	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.044862	0.277440	13,771.050000	0.025794	0.000000	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: 15-0058

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

Worksheet B-1  
Date/Time Prepared:  
5/31/2023 11:28 am

Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS		PARAMED PRGM (ASSIGNED TIME)	PARAMED (ASSIGNED TIME)	23.01
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
		17.00	21.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW 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
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	37,440					17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	2,725				21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0		2,725			22.00
23.00 02300 PARAMED PRGM-(SPECIFY)	0			100		23.00
23.01 02301 PARAMED ED	0				100	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	18,720	1,734	1,734	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	4,160	8	8	0	0	31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	2,080	0	0	0	0	31.01
40.00 04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - IRF	2,080	0	0	0	0	41.00
43.00 04300 NURSERY	2,080	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	2,080	100	100	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2,080	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,080	5	5	0	0	54.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0	33	33	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01 06602 PHYSICAL THERAPY EAST BANK	0	0	0	0	0	66.01
66.10 06601 PHYSICAL THERAPY LIVING CENTER	0	0	0	0	0	66.10
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	0	67.10
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.10 06801 SPEECH THERAPY LIVING CENTER	0	0	0	0	0	68.10
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	15	15	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03020 CARDIOLOGY	0	73	73	0	0	76.00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.10 09001 FAMILY PRACTICE CLINIC	0	606	606	0	0	90.10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	0	0	0	90.30
90.50 09004 SLEEP DISORDERS CLINIC	0	0	0	0	0	90.50
91.00 09100 EMERGENCY	2,080	143	143	100	100	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	37,440	2,717	2,717	100	100	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
193.00 19300 NONPAID WORKERS	0	8	8	0	0	193.00
193.10 19301 HEALTH PROPERTIES	0	0	0	0	0	193.10
193.40 19303 LEIGHTON CENTER	0	0	0	0	0	193.40
193.50 19305 WELLNESS CENTER	0	0	0	0	0	193.50
193.80 19308 UNUSED SPACE	0	0	0	0	0	193.80

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0058

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

Worksheet B-1

Date/Time Prepared:  
5/31/2023 11:28 am

Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS		PARAMED PRGM (ASSIGNED TIME)	PARAMED (ASSIGNED TIME)	
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
		17.00	21.00			
193.90 19309 OCCUPATIONAL HEALTH	0	0	0	0	0	193.90
193.91 19310 RESEARCH AND PROTOCOL	0	0	0	0	0	193.91
193.92 19311 CCOP	0	0	0	0	0	193.92
193.93 19312 RESEARCH ADMIN	0	0	0	0	0	193.93
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	4,473,712	2,716,092	6,529,363	176,146	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	119.490171	996.731009	2,396.096514	1,761.460000	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	247,184	7,556	642,638	645	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	6.602137	2.772844	235.830459	6.450000	0.000000	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)				0	0	206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000	0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0058

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/31/2023 11:28 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		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	128,290,453		128,290,453	0	128,290,453	30.00
31.00	03100	INTENSIVE CARE UNIT	21,941,850		21,941,850	0	21,941,850	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	15,431,987		15,431,987	0	15,431,987	31.01
40.00	04000	SUBPROVIDER - I PF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	6,455,984		6,455,984	0	6,455,984	41.00
43.00	04300	NURSERY	3,389,485		3,389,485	0	3,389,485	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	51,551,941		51,551,941	0	51,551,941	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,467,717		13,467,717	0	13,467,717	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,343,652		23,343,652	0	23,343,652	54.00
57.00	05700	CT SCAN	2,970,665		2,970,665	0	2,970,665	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,082,419		2,082,419	0	2,082,419	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,847,850		3,847,850	0	3,847,850	59.00
60.00	06000	LABORATORY	20,861,303		20,861,303	0	20,861,303	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	8,745,556	0	8,745,556	0	8,745,556	65.00
66.00	06600	PHYSICAL THERAPY	5,743,481	0	5,743,481	0	5,743,481	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	1,571,536	0	1,571,536	0	1,571,536	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	731,752	0	731,752	0	731,752	66.10
67.00	06700	OCCUPATIONAL THERAPY	2,567,483	0	2,567,483	0	2,567,483	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	439,454	0	439,454	0	439,454	67.10
68.00	06800	SPEECH PATHOLOGY	1,507,624	0	1,507,624	0	1,507,624	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	344,542	0	344,542	0	344,542	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	31,712,266		31,712,266	0	31,712,266	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,578,884		44,578,884	0	44,578,884	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,006,776		56,006,776	0	56,006,776	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
76.00	03020	CARDIOLOGY	3,861,240		3,861,240	0	3,861,240	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0		0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0		0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	2,372,674		2,372,674	0	2,372,674	90.30
90.50	09004	SLEEP DISORDERS CLINIC	1,165,846		1,165,846	0	1,165,846	90.50
91.00	09100	EMERGENCY	47,599,364		47,599,364	0	47,599,364	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	12,889,416		12,889,416	0	12,889,416	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	515,473,200	0	515,473,200	0	515,473,200	200.00
201.00		Less Observation Beds	12,889,416		12,889,416		12,889,416	201.00
202.00		Total (see instructions)	502,583,784	0	502,583,784	0	502,583,784	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0058

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/31/2023 11:28 am

		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	280,738,216		280,738,216		30.00
31.00	03100	INTENSIVE CARE UNIT	48,090,575		48,090,575		31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	29,808,678		29,808,678		31.01
40.00	04000	SUBPROVIDER - I/PF	0		0		40.00
41.00	04100	SUBPROVIDER - I/RF	15,243,763		15,243,763		41.00
43.00	04300	NURSERY	5,804,230		5,804,230		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	68,838,130	95,225,204	164,063,334	0.314220	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,105,001	1,898,828	25,003,829	0.538626	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,926,106	126,675,380	172,601,486	0.135246	54.00
57.00	05700	CT SCAN	37,284,505	49,036,926	86,321,431	0.034414	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,440,489	2,932,176	8,372,665	0.248716	58.00
59.00	05900	CARDIAC CATHETERIZATION	17,814,041	19,499,484	37,313,525	0.103122	59.00
60.00	06000	LABORATORY	120,786,855	60,945,074	181,731,929	0.114792	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	46,179,679	2,521,836	48,701,515	0.179575	65.00
66.00	06600	PHYSICAL THERAPY	6,960,082	6,480,966	13,441,048	0.427309	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	1,874	5,240,475	5,242,349	0.299777	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	3,741	2,667,519	2,671,260	0.273935	66.10
67.00	06700	OCCUPATIONAL THERAPY	6,084,980	2,058,468	8,143,448	0.315282	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	2,755	1,428,882	1,431,637	0.306959	67.10
68.00	06800	SPEECH PATHOLOGY	2,691,352	2,166,878	4,858,230	0.310324	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	6,283	1,207,902	1,214,185	0.283764	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	102,931,618	74,223,649	177,155,267	0.179008	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	126,574,046	65,474,407	192,048,453	0.232123	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	140,806,769	164,720,518	305,527,287	0.183312	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
76.00	03020	CARDIOLOGY	14,734,451	14,375,397	29,109,848	0.132644	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0.000000	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	54,990	1,561,159	1,616,149	1.468103	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	4,150,673	4,150,673	0.280881	90.50
91.00	09100	EMERGENCY	22,020,951	70,093,502	92,114,453	0.516742	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	36,115,217	36,115,217	0.356897	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	1,167,934,160	810,700,520	1,978,634,680		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	1,167,934,160	810,700,520	1,978,634,680		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/31/2023 11:28 am
Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital PPS
INPATIENT ROUTINE SERVICE COST CENTERS			11.00		
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT			31.01
40.00	04000	SUBPROVIDER - I PF			40.00
41.00	04100	SUBPROVIDER - I RF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.314220		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.538626		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.135246		54.00
57.00	05700	CT SCAN	0.034414		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.248716		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103122		59.00
60.00	06000	LABORATORY	0.114792		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.179575		65.00
66.00	06600	PHYSICAL THERAPY	0.427309		66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0.299777		66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0.273935		66.10
67.00	06700	OCCUPATIONAL THERAPY	0.315282		67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0.306959		67.10
68.00	06800	SPEECH PATHOLOGY	0.310324		68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0.283764		68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.179008		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.232123		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.183312		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	CARDIOLOGY	0.132644		76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000		77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
90.10	09001	FAMILY PRACTICE CLINIC	0.000000		90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	1.468103		90.30
90.50	09004	SLEEP DISORDERS CLINIC	0.280881		90.50
91.00	09100	EMERGENCY	0.516742		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.356897		92.00
OTHER REIMBURSABLE COST CENTERS					
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: 15-0058

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/31/2023 11:28 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		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	128,290,453		128,290,453	0	128,290,453	30.00
31.00	03100	INTENSIVE CARE UNIT	21,941,850		21,941,850	0	21,941,850	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	15,431,987		15,431,987	0	15,431,987	31.01
40.00	04000	SUBPROVIDER - I PF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	6,455,984		6,455,984	0	6,455,984	41.00
43.00	04300	NURSERY	3,389,485		3,389,485	0	3,389,485	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	51,551,941		51,551,941	0	51,551,941	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,467,717		13,467,717	0	13,467,717	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,343,652		23,343,652	0	23,343,652	54.00
57.00	05700	CT SCAN	2,970,665		2,970,665	0	2,970,665	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,082,419		2,082,419	0	2,082,419	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,847,850		3,847,850	0	3,847,850	59.00
60.00	06000	LABORATORY	20,861,303		20,861,303	0	20,861,303	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	8,745,556	0	8,745,556	0	8,745,556	65.00
66.00	06600	PHYSICAL THERAPY	5,743,481	0	5,743,481	0	5,743,481	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	1,571,536	0	1,571,536	0	1,571,536	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	731,752	0	731,752	0	731,752	66.10
67.00	06700	OCCUPATIONAL THERAPY	2,567,483	0	2,567,483	0	2,567,483	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	439,454	0	439,454	0	439,454	67.10
68.00	06800	SPEECH PATHOLOGY	1,507,624	0	1,507,624	0	1,507,624	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	344,542	0	344,542	0	344,542	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	31,712,266		31,712,266	0	31,712,266	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,578,884		44,578,884	0	44,578,884	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,006,776		56,006,776	0	56,006,776	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
76.00	03020	CARDIOLOGY	3,861,240		3,861,240	0	3,861,240	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0		0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0		0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	2,372,674		2,372,674	0	2,372,674	90.30
90.50	09004	SLEEP DISORDERS CLINIC	1,165,846		1,165,846	0	1,165,846	90.50
91.00	09100	EMERGENCY	47,599,364		47,599,364	0	47,599,364	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	12,889,416		12,889,416	0	12,889,416	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	515,473,200	0	515,473,200	0	515,473,200	200.00
201.00		Less Observation Beds	12,889,416		12,889,416		12,889,416	201.00
202.00		Total (see instructions)	502,583,784	0	502,583,784	0	502,583,784	202.00



COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0058

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/31/2023 11:28 am

		Title XIX			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			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	280,738,216		280,738,216		30.00
31.00	03100	INTENSIVE CARE UNIT	48,090,575		48,090,575		31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	29,808,678		29,808,678		31.01
40.00	04000	SUBPROVIDER - I/PF	0		0		40.00
41.00	04100	SUBPROVIDER - I/RF	15,243,763		15,243,763		41.00
43.00	04300	NURSERY	5,804,230		5,804,230		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	68,838,130	95,225,204	164,063,334	0.314220	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,105,001	1,898,828	25,003,829	0.538626	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,926,106	126,675,380	172,601,486	0.135246	54.00
57.00	05700	CT SCAN	37,284,505	49,036,926	86,321,431	0.034414	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,440,489	2,932,176	8,372,665	0.248716	58.00
59.00	05900	CARDIAC CATHETERIZATION	17,814,041	19,499,484	37,313,525	0.103122	59.00
60.00	06000	LABORATORY	120,786,855	60,945,074	181,731,929	0.114792	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	46,179,679	2,521,836	48,701,515	0.179575	65.00
66.00	06600	PHYSICAL THERAPY	6,960,082	6,480,966	13,441,048	0.427309	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	1,874	5,240,475	5,242,349	0.299777	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	3,741	2,667,519	2,671,260	0.273935	66.10
67.00	06700	OCCUPATIONAL THERAPY	6,084,980	2,058,468	8,143,448	0.315282	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	2,755	1,428,882	1,431,637	0.306959	67.10
68.00	06800	SPEECH PATHOLOGY	2,691,352	2,166,878	4,858,230	0.310324	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	6,283	1,207,902	1,214,185	0.283764	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	102,931,618	74,223,649	177,155,267	0.179008	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	126,574,046	65,474,407	192,048,453	0.232123	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	140,806,769	164,720,518	305,527,287	0.183312	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
76.00	03020	CARDIOLOGY	14,734,451	14,375,397	29,109,848	0.132644	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0.000000	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	54,990	1,561,159	1,616,149	1.468103	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	4,150,673	4,150,673	0.280881	90.50
91.00	09100	EMERGENCY	22,020,951	70,093,502	92,114,453	0.516742	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	36,115,217	36,115,217	0.356897	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	1,167,934,160	810,700,520	1,978,634,680		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	1,167,934,160	810,700,520	1,978,634,680		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/31/2023 11:28 am
Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital
			11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT			31.01
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.314220		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.538626		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.135246		54.00
57.00	05700	CT SCAN	0.034414		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.248716		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103122		59.00
60.00	06000	LABORATORY	0.114792		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.179575		65.00
66.00	06600	PHYSICAL THERAPY	0.427309		66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0.299777		66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0.273935		66.10
67.00	06700	OCCUPATIONAL THERAPY	0.315282		67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0.306959		67.10
68.00	06800	SPEECH PATHOLOGY	0.310324		68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0.283764		68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.179008		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.232123		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.183312		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	CARDIOLOGY	0.132644		76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000		77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
90.10	09001	FAMILY PRACTICE CLINIC	0.000000		90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	1.468103		90.30
90.50	09004	SLEEP DISORDERS CLINIC	0.280881		90.50
91.00	09100	EMERGENCY	0.516742		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.356897		92.00
OTHER REIMBURSABLE COST CENTERS					
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: 15-0058

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

Worksheet C  
Part II  
Date/Time Prepared:  
5/31/2023 11:28 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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	51,551,941	4,392,238	47,159,703	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,467,717	1,317,445	12,150,272	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,343,652	2,822,891	20,520,761	0	0	54.00
57.00	05700	CT SCAN	2,970,665	107,367	2,863,298	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,082,419	153,265	1,929,154	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,847,850	567,846	3,280,004	0	0	59.00
60.00	06000	LABORATORY	20,861,303	463,234	20,398,069	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	8,745,556	280,862	8,464,694	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,743,481	476,093	5,267,388	0	0	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	1,571,536	5,733	1,565,803	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	731,752	2,595	729,157	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	2,567,483	73,840	2,493,643	0	0	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	439,454	1,603	437,851	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	1,507,624	19,112	1,488,512	0	0	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	344,542	1,217	343,325	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	31,712,266	901,383	30,810,883	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,578,884	643,909	43,934,975	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,006,776	807,264	55,199,512	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	CARDIOLOGY	3,861,240	126,757	3,734,483	0	0	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	2,372,674	631,269	1,741,405	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	1,165,846	109,600	1,056,246	0	0	90.50
91.00	09100	EMERGENCY	47,599,364	3,226,826	44,372,538	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	12,889,416	1,120,168	11,769,248	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	339,963,441	18,252,517	321,710,924	0	0	200.00
201.00		Less Observation Beds	12,889,416	1,120,168	11,769,248	0	0	201.00
202.00		Total (line 200 minus line 201)	327,074,025	17,132,349	309,941,676	0	0	202.00

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

Provider CCN: 15-0058

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

Worksheet C Part II Date/Time Prepared: 5/31/2023 11:28 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)		
		6.00	7.00	8.00		
Title XIX						
Hospital						
PPS						
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	51,551,941	164,063,334	0.314220	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,467,717	25,003,829	0.538626	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,343,652	172,601,486	0.135246	54.00
57.00	05700	CT SCAN	2,970,665	86,321,431	0.034414	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,082,419	8,372,665	0.248716	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,847,850	37,313,525	0.103122	59.00
60.00	06000	LABORATORY	20,861,303	181,731,929	0.114792	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	8,745,556	48,701,515	0.179575	65.00
66.00	06600	PHYSICAL THERAPY	5,743,481	13,441,048	0.427309	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	1,571,536	5,242,349	0.299777	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	731,752	2,671,260	0.273935	66.10
67.00	06700	OCCUPATIONAL THERAPY	2,567,483	8,143,448	0.315282	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	439,454	1,431,637	0.306959	67.10
68.00	06800	SPEECH PATHOLOGY	1,507,624	4,858,230	0.310324	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	344,542	1,214,185	0.283764	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	31,712,266	177,155,267	0.179008	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,578,884	192,048,453	0.232123	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,006,776	305,527,287	0.183312	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	74.00
76.00	03020	CARDIOLOGY	3,861,240	29,109,848	0.132644	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	0	0.000000	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0.000000	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	2,372,674	1,616,149	1.468103	90.30
90.50	09004	SLEEP DISORDERS CLINIC	1,165,846	4,150,673	0.280881	90.50
91.00	09100	EMERGENCY	47,599,364	92,114,453	0.516742	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	12,889,416	36,115,217	0.356897	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0.000000	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (sum of lines 50 thru 199)	339,963,441	1,598,949,218		200.00
201.00		Less Observation Beds	12,889,416	0		201.00
202.00		Total (line 200 minus line 201)	327,074,025	1,598,949,218		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part I Date/Time Prepared: 5/31/2023 11:28 am
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Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	11,149,229	0	11,149,229	97,939	113.84	30.00	
31.00	INTENSIVE CARE UNIT	1,386,909		1,386,909	7,146	194.08	31.00	
31.01	NEONATAL INTENSIVE CARE UNIT	1,247,319		1,247,319	8,604	144.97	31.01	
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00	
41.00	SUBPROVIDER - IRF	530,341	0	530,341	4,924	107.71	41.00	
43.00	NURSERY	196,242		196,242	3,953	49.64	43.00	
200.00	Total (lines 30 through 199)	14,510,040		14,510,040	122,566		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	20,560	2,340,550					30.00
31.00	INTENSIVE CARE UNIT	1,758	341,193					31.00
31.01	NEONATAL INTENSIVE CARE UNIT	0	0					31.01
40.00	SUBPROVIDER - IPF	0	0					40.00
41.00	SUBPROVIDER - IRF	1,245	134,099					41.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	23,563	2,815,842					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0058

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

Worksheet D  
Part II  
Date/Time Prepared:  
5/31/2023 11:28 am

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)	Hospital		Capital Costs (column 3 x column 4)	
					Inpatient Program Charges	PPS		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,392,238	164,063,334	0.026772	15,494,560	414,820	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,317,445	25,003,829	0.052690	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,822,891	172,601,486	0.016355	14,790,111	241,892	54.00
57.00	05700	CT SCAN	107,367	86,321,431	0.001244	6,862,637	8,537	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	153,265	8,372,665	0.018305	1,207,406	22,102	58.00
59.00	05900	CARDIAC CATHETERIZATION	567,846	37,313,525	0.015218	4,244,414	64,591	59.00
60.00	06000	LABORATORY	463,234	181,731,929	0.002549	26,122,866	66,587	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	280,862	48,701,515	0.005767	11,617,870	67,000	65.00
66.00	06600	PHYSICAL THERAPY	476,093	13,441,048	0.035421	1,455,037	51,539	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	5,733	5,242,349	0.001094	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	2,595	2,671,260	0.000971	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	73,840	8,143,448	0.009067	1,078,839	9,782	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	1,603	1,431,637	0.001120	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	19,112	4,858,230	0.003934	387,484	1,524	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	1,217	1,214,185	0.001002	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	901,383	177,155,267	0.005088	20,083,058	102,183	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	643,909	192,048,453	0.003353	30,485,985	102,220	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	807,264	305,527,287	0.002642	32,258,884	85,228	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03020	CARDIOLOGY	126,757	29,109,848	0.004354	4,059,576	17,675	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0.000000	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	631,269	1,616,149	0.390601	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	109,600	4,150,673	0.026405	0	0	90.50
91.00	09100	EMERGENCY	3,226,826	92,114,453	0.035031	5,641,492	197,627	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,120,168	36,115,217	0.031017	0	0	92.00
200.00		Total (lines 50 through 199)	18,252,517	1,598,949,218		175,790,219	1,453,307	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Prepared: 5/31/2023 11:28 am
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Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31.01	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	97,939	0.00	20,560	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	7,146	0.00	1,758	31.00	
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	8,604	0.00	0	31.01	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	4,924	0.00	1,245	41.00	
43.00	04300	NURSERY	0	0	3,953	0.00	0	43.00	
200.00		Total (lines 30 through 199)	0	0	122,566	0.00	23,563	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0						31.01
40.00	04000	SUBPROVIDER - IPF	0						40.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0058

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/31/2023 11:28 am

Cost Center Description		Title XVIII					Hospital	
		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	PPS	
		1.00	2A	2.00	3A	3.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0	0	0	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	0	0	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0	0	0	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	CARDIOLOGY	0	0	0	0	0	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0	0	0	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	0	0	0	0	90.50
91.00	09100	EMERGENCY	0	0	0	0	176,146	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	176,146	200.00



APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/31/2023 11:28 am
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	Title XVIII		
						Hospital	PPS	
	4.00	5.00	6.00	7.00	8.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	164,063,334	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	25,003,829	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	172,601,486	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	86,321,431	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	8,372,665	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	37,313,525	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	181,731,929	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	48,701,515	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,441,048	0.000000	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0	0	0	5,242,349	0.000000	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	0	0	2,671,260	0.000000	66.10
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	8,143,448	0.000000	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	1,431,637	0.000000	67.10
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,858,230	0.000000	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0	0	0	1,214,185	0.000000	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	177,155,267	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	192,048,453	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	305,527,287	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
76.00	03020	CARDIOLOGY	0	0	0	29,109,848	0.000000	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0.000000	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0	0	0	1,616,149	0.000000	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	0	0	4,150,673	0.000000	90.50
91.00	09100	EMERGENCY	0	176,146	176,146	92,114,453	0.001912	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	36,115,217	0.000000	92.00
200.00		Total (lines 50 through 199)	0	176,146	176,146	1,598,949,218		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0058

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/31/2023 11:28 am

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	15,494,560	0	14,846,682	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	14,790,111	0	26,917,700	0	54.00
57.00	05700 CT SCAN	0.000000	6,862,637	0	8,454,806	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	1,207,406	0	261,832	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	4,244,414	0	7,042,982	0	59.00
60.00	06000 LABORATORY	0.000000	26,122,866	0	8,049,884	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.000000	11,617,870	0	399,688	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	1,455,037	0	1,449,781	0	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0.000000	0	0	34,705	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0.000000	0	0	12,541	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	0.000000	1,078,839	0	35,749	0	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0.000000	0	0	27,011	0	67.10
68.00	06800 SPEECH PATHOLOGY	0.000000	387,484	0	3,464	0	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0.000000	0	0	4,952	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	20,083,058	0	14,210,331	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	30,485,985	0	15,629,768	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	32,258,884	0	46,301,486	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03020 CARDIOLOGY	0.000000	4,059,576	0	3,470,615	0	76.00
77.00	07700 ALLOGENEIC STEM CELL 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
90.10	09001 FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	0.000000	0	0	0	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0.000000	0	0	477,795	0	90.50
91.00	09100 EMERGENCY	0.001912	5,641,492	10,787	4,877,516	9,326	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	1,265	0	92.00
200.00	Total (lines 50 through 199)		175,790,219	10,787	152,510,553	9,326	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/31/2023 11:28 am
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		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.314220	14,846,682	0	0	4,665,124	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.538626	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.135246	26,917,700	0	0	3,640,511	54.00
57.00	05700	CT SCAN	0.034414	8,454,806	0	0	290,964	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.248716	261,832	0	0	65,122	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103122	7,042,982	0	0	726,286	59.00
60.00	06000	LABORATORY	0.114792	8,049,884	0	0	924,062	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.179575	399,688	0	0	71,774	65.00
66.00	06600	PHYSICAL THERAPY	0.427309	1,449,781	0	0	619,504	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0.299777	34,705	0	0	10,404	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0.273935	12,541	0	0	3,435	66.10
67.00	06700	OCCUPATIONAL THERAPY	0.315282	35,749	0	0	11,271	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0.306959	27,011	0	0	8,291	67.10
68.00	06800	SPEECH PATHOLOGY	0.310324	3,464	0	0	1,075	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0.283764	4,952	0	0	1,405	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.179008	14,210,331	280	0	2,543,763	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.232123	15,629,768	634	0	3,628,029	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.183312	46,301,486	0	0	8,487,618	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03020	CARDIOLOGY	0.132644	3,470,615	0	0	460,356	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	1.468103	0	0	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0.280881	477,795	0	0	134,204	90.50
91.00	09100	EMERGENCY	0.516742	4,877,516	0	0	2,520,417	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.356897	1,265	0	0	451	92.00
200.00		Subtotal (see instructions)		152,510,553	914	0	28,814,066	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		152,510,553	914	0	28,814,066	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/31/2023 11:28 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		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
66.01 06602 PHYSICAL THERAPY EAST BANK	0	0		66.01
66.10 06601 PHYSICAL THERAPY LIVING CENTER	0	0		66.10
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0		67.10
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
68.10 06801 SPEECH THERAPY LIVING CENTER	0	0		68.10
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	50	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	147	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03020 RADIOLOGY	0	0		76.00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
90.10 09001 FAMILY PRACTICE CLINIC	0	0		90.10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	0		90.30
90.50 09004 SLEEP DISORDERS CLINIC	0	0		90.50
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Subtotal (see instructions)	197	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	197	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Prepared: 5/31/2023 11:28 am
Title XVIII			Subprovider - IRF	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,392,238	164,063,334	0.026772	16,992	455	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,317,445	25,003,829	0.052690	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,822,891	172,601,486	0.016355	24,354	398	54.00
57.00	05700	CT SCAN	107,367	86,321,431	0.001244	28,355	35	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	153,265	8,372,665	0.018305	1,756	32	58.00
59.00	05900	CARDIAC CATHETERIZATION	567,846	37,313,525	0.015218	0	0	59.00
60.00	06000	LABORATORY	463,234	181,731,929	0.002549	296,270	755	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	280,862	48,701,515	0.005767	132,080	762	65.00
66.00	06600	PHYSICAL THERAPY	476,093	13,441,048	0.035421	558,490	19,782	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	5,733	5,242,349	0.001094	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	2,595	2,671,260	0.000971	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	73,840	8,143,448	0.009067	579,811	5,257	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	1,603	1,431,637	0.001120	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	19,112	4,858,230	0.003934	272,739	1,073	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	1,217	1,214,185	0.001002	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	901,383	177,155,267	0.005088	5,270	27	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	643,909	192,048,453	0.003353	2,400	8	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	807,264	305,527,287	0.002642	685,638	1,811	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03020	CARDIOLOGY	126,757	29,109,848	0.004354	0	0	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0.000000	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	631,269	1,616,149	0.390601	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	109,600	4,150,673	0.026405	0	0	90.50
91.00	09100	EMERGENCY	3,226,826	92,114,453	0.035031	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	36,115,217	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	17,132,349	1,598,949,218		2,604,155	30,395	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/31/2023 11:28 am
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Cost Center Description		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0	0	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	0	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0	0	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	CARDIOLOGY	0	0	0	0	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0	0	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	0	0	0	90.50
91.00	09100	EMERGENCY	0	0	0	176,146	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	176,146	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/31/2023 11:28 am
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7) (see instructions)	
		4.00	5.00	6.00	7.00	8.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	164,063,334	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	25,003,829	0.000000	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	172,601,486	0.000000	54.00
57.00	05700 CT SCAN	0	0	0	86,321,431	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	8,372,665	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	37,313,525	0.000000	59.00
60.00	06000 LABORATORY	0	0	0	181,731,929	0.000000	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	48,701,515	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	13,441,048	0.000000	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0	0	0	5,242,349	0.000000	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0	0	0	2,671,260	0.000000	66.10
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	8,143,448	0.000000	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	1,431,637	0.000000	67.10
68.00	06800 SPEECH PATHOLOGY	0	0	0	4,858,230	0.000000	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0	0	0	1,214,185	0.000000	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	177,155,267	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	192,048,453	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	305,527,287	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0.000000	74.00
76.00	03020 RADIOLOGY	0	0	0	29,109,848	0.000000	76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0.000000	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0	0	0	0	0.000000	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	0	1,616,149	0.000000	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0	0	0	4,150,673	0.000000	90.50
91.00	09100 EMERGENCY	0	176,146	176,146	92,114,453	0.001912	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	36,115,217	0.000000	92.00
200.00	Total (lines 50 through 199)	0	176,146	176,146	1,598,949,218		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/31/2023 11:28 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	16,992	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	24,354	0	0	0	54.00
57.00	05700 CT SCAN	0.000000	28,355	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	1,756	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	296,270	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.000000	132,080	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	558,490	0	0	0	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0.000000	0	0	0	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0.000000	0	0	0	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	0.000000	579,811	0	0	0	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0.000000	0	0	0	0	67.10
68.00	06800 SPEECH PATHOLOGY	0.000000	272,739	0	0	0	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0.000000	0	0	0	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	5,270	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,400	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	685,638	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03020 CARDIOLOGY	0.000000	0	0	0	0	76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	0.000000	0	0	0	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0.000000	0	0	0	0	90.50
91.00	09100 EMERGENCY	0.001912	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		2,604,155	0	0	0	200.00



APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part I Date/Time Prepared: 5/31/2023 11:28 am
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Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	11,149,229	0	11,149,229	97,939	113.84	30.00	
31.00	INTENSIVE CARE UNIT	1,386,909		1,386,909	7,146	194.08	31.00	
31.01	NEONATAL INTENSIVE CARE UNIT	1,247,319		1,247,319	8,604	144.97	31.01	
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00	
41.00	SUBPROVIDER - IRF	530,341	0	530,341	4,924	107.71	41.00	
43.00	NURSERY	196,242		196,242	3,953	49.64	43.00	
200.00	Total (lines 30 through 199)	14,510,040		14,510,040	122,566		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	4,338	493,838					30.00
31.00	INTENSIVE CARE UNIT	90	17,467					31.00
31.01	NEONATAL INTENSIVE CARE UNIT	1,132	164,106					31.01
40.00	SUBPROVIDER - IPF	0	0					40.00
41.00	SUBPROVIDER - IRF	34	3,662					41.00
43.00	NURSERY	350	17,374					43.00
200.00	Total (lines 30 through 199)	5,944	696,447					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0058

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

Worksheet D  
Part II  
Date/Time Prepared:  
5/31/2023 11:28 am

Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	4,392,238	164,063,334	0.026772	37,823,488	1,012,610	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,317,445	25,003,829	0.052690	14,144,114	745,253	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,822,891	172,601,486	0.016355	11,659,913	190,698	54.00
57.00	05700	CT SCAN	107,367	86,321,431	0.001244	9,032,753	11,237	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	153,265	8,372,665	0.018305	1,271,044	23,266	58.00
59.00	05900	CARDIAC CATHETERIZATION	567,846	37,313,525	0.015218	3,534,417	53,787	59.00
60.00	06000	LABORATORY	463,234	181,731,929	0.002549	30,326,537	77,302	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	280,862	48,701,515	0.005767	17,605,634	101,532	65.00
66.00	06600	PHYSICAL THERAPY	476,093	13,441,048	0.035421	1,869	66	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	5,733	5,242,349	0.001094	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	2,595	2,671,260	0.000971	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	73,840	8,143,448	0.009067	258	2	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	1,603	1,431,637	0.001120	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	19,112	4,858,230	0.003934	0	0	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	1,217	1,214,185	0.001002	258	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	901,383	177,155,267	0.005088	669,662	3,407	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	643,909	192,048,453	0.003353	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	807,264	305,527,287	0.002642	2,875,405	7,597	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03020	CARDIOLOGY	126,757	29,109,848	0.004354	2,322,464	10,112	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0.000000	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	631,269	1,616,149	0.390601	48,134	18,801	90.30
90.50	09004	SLEEP DISORDERS CLINIC	109,600	4,150,673	0.026405	0	0	90.50
91.00	09100	EMERGENCY	3,226,826	92,114,453	0.035031	5,481,772	192,032	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,120,168	36,115,217	0.031017	0	0	92.00
200.00		Total (lines 50 through 199)	18,252,517	1,598,949,218		136,797,722	2,447,702	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Prepared: 5/31/2023 11:28 am
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Cost Center Description		Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
		1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00	
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	31.01	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	200.00	
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
		4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	97,939	0.00	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	7,146	0.00	31.00	
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	8,604	0.00	31.01	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	4,924	0.00	41.00	
43.00	04300	NURSERY	0	0	3,953	0.00	43.00	
200.00		Total (lines 30 through 199)	0	0	122,566	0.00	200.00	
Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
		9.00						
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0					30.00
31.00	03100	INTENSIVE CARE UNIT	0					31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0					31.01
40.00	04000	SUBPROVIDER - IPF	0					40.00
41.00	04100	SUBPROVIDER - IRF	0					41.00
43.00	04300	NURSERY	0					43.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0058

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/31/2023 11:28 am

Cost Center Description		Title XIX			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health		
		1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0	0	0	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	0	0	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0	0	0	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	CARDIOLOGY	0	0	0	0	0	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0	0	0	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	0	0	0	0	90.50
91.00	09100	EMERGENCY	0	0	0	0	176,146	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	176,146	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0058

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/31/2023 11:28 am

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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	164,063,334	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	25,003,829	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	172,601,486	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	86,321,431	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	8,372,665	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	37,313,525	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	181,731,929	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	48,701,515	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,441,048	0.000000	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0	0	0	5,242,349	0.000000	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	0	0	2,671,260	0.000000	66.10
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	8,143,448	0.000000	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	1,431,637	0.000000	67.10
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,858,230	0.000000	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0	0	0	1,214,185	0.000000	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	177,155,267	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	192,048,453	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	305,527,287	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
76.00	03020	CARDIOLOGY	0	0	0	29,109,848	0.000000	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0.000000	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0	0	0	1,616,149	0.000000	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	0	0	4,150,673	0.000000	90.50
91.00	09100	EMERGENCY	0	176,146	176,146	92,114,453	0.001912	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	36,115,217	0.000000	92.00
200.00		Total (lines 50 through 199)	0	176,146	176,146	1,598,949,218		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/31/2023 11:28 am
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Cost Center Description		Title XIX				Hospital	
		Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PPS
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	37,823,488	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	14,144,114	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	11,659,913	0	0	0	54.00
57.00	05700 CT SCAN	0.000000	9,032,753	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	1,271,044	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	3,534,417	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	30,326,537	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.000000	17,605,634	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	1,869	0	0	0	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0.000000	0	0	0	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0.000000	0	0	0	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	0.000000	258	0	0	0	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0.000000	0	0	0	0	67.10
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0.000000	258	0	0	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	669,662	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	2,875,405	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03020 CARDIOLOGY	0.000000	2,322,464	0	0	0	76.00
77.00	07700 ALLOGENEIC STEM CELL 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
90.10	09001 FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	0.000000	48,134	0	0	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0.000000	0	0	0	0	90.50
91.00	09100 EMERGENCY	0.001912	5,481,772	10,481	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		136,797,722	10,481	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Prepared: 5/31/2023 11:28 am
Title XIX			Subprovider - IRF	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	4,392,238	164,063,334	0.026772	6,129	164	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,317,445	25,003,829	0.052690	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,822,891	172,601,486	0.016355	28,969	474	54.00
57.00	05700 CT SCAN	107,367	86,321,431	0.001244	14,530	18	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	153,265	8,372,665	0.018305	11,799	216	58.00
59.00	05900 CARDIAC CATHETERIZATION	567,846	37,313,525	0.015218	0	0	59.00
60.00	06000 LABORATORY	463,234	181,731,929	0.002549	193,059	492	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	280,862	48,701,515	0.005767	15,583	90	65.00
66.00	06600 PHYSICAL THERAPY	476,093	13,441,048	0.035421	418,880	14,837	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	5,733	5,242,349	0.001094	0	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	2,595	2,671,260	0.000971	0	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	73,840	8,143,448	0.009067	385,877	3,499	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	1,603	1,431,637	0.001120	0	0	67.10
68.00	06800 SPEECH PATHOLOGY	19,112	4,858,230	0.003934	213,428	840	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	1,217	1,214,185	0.001002	0	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	901,383	177,155,267	0.005088	4,719	24	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	643,909	192,048,453	0.003353	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	807,264	305,527,287	0.002642	585,555	1,547	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03020 RADIOLOGY	126,757	29,109,848	0.004354	3,099	13	76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0	0	0.000000	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	631,269	1,616,149	0.390601	0	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	109,600	4,150,673	0.026405	0	0	90.50
91.00	09100 EMERGENCY	3,226,826	92,114,453	0.035031	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	36,115,217	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	17,132,349	1,598,949,218		1,881,627	22,214	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/31/2023 11:28 am
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Cost Center Description		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0	0	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	0	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0	0	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	CARDIOLOGY	0	0	0	0	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0	0	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	0	0	0	90.50
91.00	09100	EMERGENCY	0	0	0	176,146	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	176,146	200.00



APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/31/2023 11:28 am
Title XIX		Subprovider - IRF	PPS

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7) (see instructions)	
		4.00	5.00	6.00	7.00	8.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	164,063,334	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	25,003,829	0.000000	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	172,601,486	0.000000	54.00
57.00	05700 CT SCAN	0	0	0	86,321,431	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	8,372,665	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	37,313,525	0.000000	59.00
60.00	06000 LABORATORY	0	0	0	181,731,929	0.000000	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	48,701,515	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	13,441,048	0.000000	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0	0	0	5,242,349	0.000000	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0	0	0	2,671,260	0.000000	66.10
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	8,143,448	0.000000	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	1,431,637	0.000000	67.10
68.00	06800 SPEECH PATHOLOGY	0	0	0	4,858,230	0.000000	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0	0	0	1,214,185	0.000000	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	177,155,267	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	192,048,453	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	305,527,287	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0.000000	74.00
76.00	03020 RADIOLOGY	0	0	0	29,109,848	0.000000	76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0.000000	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0	0	0	0	0.000000	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	0	1,616,149	0.000000	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0	0	0	4,150,673	0.000000	90.50
91.00	09100 EMERGENCY	0	176,146	176,146	92,114,453	0.001912	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	36,115,217	0.000000	92.00
200.00	Total (lines 50 through 199)	0	176,146	176,146	1,598,949,218		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/31/2023 11:28 am
	Title XIX	Subprovider - IRF	PPS

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	6,129	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	28,969	0	0	0	54.00
57.00	05700 CT SCAN	0.000000	14,530	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	11,799	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	193,059	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.000000	15,583	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	418,880	0	0	0	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0.000000	0	0	0	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0.000000	0	0	0	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	0.000000	385,877	0	0	0	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0.000000	0	0	0	0	67.10
68.00	06800 SPEECH PATHOLOGY	0.000000	213,428	0	0	0	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0.000000	0	0	0	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	4,719	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	585,555	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03020 RADIOLOGY	0.000000	3,099	0	0	0	76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	0.000000	0	0	0	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0.000000	0	0	0	0	90.50
91.00	09100 EMERGENCY	0.001912	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		1,881,627	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/31/2023 11:28 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		97,939	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		97,939	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)		88,099	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)		20,560	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
<b>SWING BED ADJUSTMENT</b>				
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)		128,290,453	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)		128,290,453	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		128,290,453	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,309.90	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		26,931,544	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)		26,931,544	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/31/2023 11:28 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	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	21,941,850	7,146	3,070.51	1,758	5,397,957	43.00
43.01 NEONATAL INTENSIVE CARE UNIT	15,431,987	8,604	1,793.58	0	0	43.01
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)					34,048,919	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)					66,378,420	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)					2,681,743	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,464,094	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					4,145,837	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					62,232,583	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)					9,840	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,309.90	88.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/31/2023 11:28 am	
Cost Center Description		Title XVIII		Hospital		PPS	
Cost Center Description		Cost		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)					12,889,416	89.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	11,149,229	128,290,453	0.086906	12,889,416	1,120,168	90.00
91.00	Nursing Program cost	0	128,290,453	0.000000	12,889,416	0	91.00
92.00	Allied health cost	0	128,290,453	0.000000	12,889,416	0	92.00
93.00	All other Medical Education	0	128,290,453	0.000000	12,889,416	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/31/2023 11:28 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,924	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,924	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)		4,924	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,245	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
<b>SWING BED ADJUSTMENT</b>				
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)		6,455,984	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)		6,455,984	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		6,455,984	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,311.13	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,632,357	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)		1,632,357	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1	
				Component CCN: 15-T058		Date/Time Prepared: 5/31/2023 11:28 am	
				Title XVIII	Subprovider - IRF	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.01
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
<b>Cost Center Description</b>							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					701,048		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)					2,333,405		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					134,099		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					30,395		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					164,494		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,168,911		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00 Total observation bed days (see instructions)					0		87.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/31/2023 11:28 am
		Title XVIII	Subprovider - IRF	PPS

Cost Center Description						1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 + line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00
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	530,341	6,455,984	0.082147	0	0	90.00
91.00	Nursing Program cost	0	6,455,984	0.000000	0	0	91.00
92.00	Allied health cost	0	6,455,984	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,455,984	0.000000	0	0	93.00



COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/31/2023 11:28 am
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		97,939	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		97,939	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)		88,099	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		4,338	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		3,953	15.00
16.00	Nursery days (title V or XIX only)		350	16.00
<b>SWING BED ADJUSTMENT</b>				
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)		128,290,453	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)		128,290,453	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		128,290,453	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,309.90	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,682,346	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		5,682,346	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/31/2023 11:28 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)	
42.00 NURSERY (title V & XIX only)	3,389,485	3,953	857.45	350	300,108	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	21,941,850	7,146	3,070.51	90	276,346	43.00
43.01 NEONATAL INTENSIVE CARE UNIT	15,431,987	8,604	1,793.58	1,132	2,030,333	43.01
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)					32,573,788	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)					40,862,921	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)					692,785	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,458,183	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					3,150,968	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					37,711,953	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)					9,840	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,309.90	88.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/31/2023 11:28 am	
Cost Center Description		Title XIX		Hospital		PPS	
Cost Center Description		Cost		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)					12,889,416	89.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	11,149,229	128,290,453	0.086906	12,889,416	1,120,168	90.00
91.00	Nursing Program cost	0	128,290,453	0.000000	12,889,416	0	91.00
92.00	Allied health cost	0	128,290,453	0.000000	12,889,416	0	92.00
93.00	All other Medical Education	0	128,290,453	0.000000	12,889,416	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/31/2023 11:28 am
		Title XIX	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,924 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			4,924 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)			4,924 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)			34 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			3,953 15.00
16.00	Nursery days (title V or XIX only)			350 16.00
<b>SWING BED ADJUSTMENT</b>				
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)			6,455,984 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)			6,455,984 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)			6,455,984 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,311.13 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			44,578 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)			44,578 41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1
					Component CCN: 15-T058		Date/Time Prepared: 5/31/2023 11:28 am
					Title XIX	Subprovider - IRF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.01
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
<b>Cost Center Description</b>							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					509,717		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)					554,295		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					3,662		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					22,214		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					25,876		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					528,419		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00 Total observation bed days (see instructions)					0		87.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/31/2023 11:28 am
		Title XIX	Subprovider - IRF	PPS

Cost Center Description						1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 + line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00
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	530,341	6,455,984	0.082147	0	0	90.00
91.00	Nursing Program cost	0	6,455,984	0.000000	0	0	91.00
92.00	Allied health cost	0	6,455,984	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,455,984	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/31/2023 11:28 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		63,035,248	30.00
31.00	03100	INTENSIVE CARE UNIT		9,108,420	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		0	31.01
40.00	04000	SUBPROVIDER - I PF		0	40.00
41.00	04100	SUBPROVIDER - I RF		0	41.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.314220	15,494,560	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.538626	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.135246	14,790,111	54.00
57.00	05700	CT SCAN	0.034414	6,862,637	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.248716	1,207,406	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103122	4,244,414	59.00
60.00	06000	LABORATORY	0.114792	26,122,866	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.179575	11,617,870	65.00
66.00	06600	PHYSICAL THERAPY	0.427309	1,455,037	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0.299777	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0.273935	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	0.315282	1,078,839	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0.306959	0	67.10
68.00	06800	SPEECH PATHOLOGY	0.310324	387,484	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0.283764	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.179008	20,083,058	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.232123	30,485,985	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.183312	32,258,884	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
76.00	03020	CARDIOLOGY	0.132644	4,059,576	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0.000000	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	1.468103	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0.280881	0	90.50
91.00	09100	EMERGENCY	0.516742	5,641,492	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.356897	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		175,790,219	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)		175,790,219	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/31/2023 11:28 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT			31.01
40.00	04000	SUBPROVIDER - I PF			40.00
41.00	04100	SUBPROVIDER - IRF		4,055,195	41.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.314220	16,992	5,339 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.538626	0	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.135246	24,354	3,294 54.00
57.00	05700	CT SCAN	0.034414	28,355	976 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.248716	1,756	437 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103122	0	0 59.00
60.00	06000	LABORATORY	0.114792	296,270	34,009 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0.179575	132,080	23,718 65.00
66.00	06600	PHYSICAL THERAPY	0.427309	558,490	238,648 66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0.299777	0	0 66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0.273935	0	0 66.10
67.00	06700	OCCUPATIONAL THERAPY	0.315282	579,811	182,804 67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0.306959	0	0 67.10
68.00	06800	SPEECH PATHOLOGY	0.310324	272,739	84,637 68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0.283764	0	0 68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.179008	5,270	943 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.232123	2,400	557 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.183312	685,638	125,686 73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0 74.00
76.00	03020	CARDIOLOGY	0.132644	0	0 76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0 77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000	0	0 90.00
90.10	09001	FAMILY PRACTICE CLINIC	0.000000	0	0 90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	1.468103	0	0 90.30
90.50	09004	SLEEP DISORDERS CLINIC	0.280881	0	0 90.50
91.00	09100	EMERGENCY	0.516742	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.356897	0	0 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,604,155	701,048 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		2,604,155	202.00



INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/31/2023 11:28 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		53,738,294	30.00
31.00	03100	INTENSIVE CARE UNIT		16,993,135	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		19,973,465	31.01
40.00	04000	SUBPROVIDER - I PF		0	40.00
41.00	04100	SUBPROVIDER - I RF		113,976	41.00
43.00	04300	NURSERY		2,037,654	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.314220	37,823,488	11,884,896 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.538626	14,144,114	7,618,388 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.135246	11,659,913	1,576,957 54.00
57.00	05700	CT SCAN	0.034414	9,032,753	310,853 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.248716	1,271,044	316,129 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103122	3,534,417	364,476 59.00
60.00	06000	LABORATORY	0.114792	30,326,537	3,481,244 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0.179575	17,605,634	3,161,532 65.00
66.00	06600	PHYSICAL THERAPY	0.427309	1,869	799 66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0.299777	0	0 66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0.273935	0	0 66.10
67.00	06700	OCCUPATIONAL THERAPY	0.315282	258	81 67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0.306959	0	0 67.10
68.00	06800	SPEECH PATHOLOGY	0.310324	0	0 68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0.283764	258	73 68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.179008	669,662	119,875 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.232123	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.183312	2,875,405	527,096 73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0 74.00
76.00	03020	CARDIOLOGY	0.132644	2,322,464	308,061 76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0 77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000	0	0 90.00
90.10	09001	FAMILY PRACTICE CLINIC	0.000000	0	0 90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	1.468103	48,134	70,666 90.30
90.50	09004	SLEEP DISORDERS CLINIC	0.280881	0	0 90.50
91.00	09100	EMERGENCY	0.516742	5,481,772	2,832,662 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.356897	0	0 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		136,797,722	32,573,788 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		136,797,722	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/31/2023 11:28 am	
		Title XIX	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT				31.01
40.00	04000 SUBPROVIDER - I PF				40.00
41.00	04100 SUBPROVIDER - IRF				41.00
43.00	04300 NURSERY		3,078,881		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.314220	6,129	1,926	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.538626	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.135246	28,969	3,918	54.00
57.00	05700 CT SCAN	0.034414	14,530	500	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.248716	11,799	2,935	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.103122	0	0	59.00
60.00	06000 LABORATORY	0.114792	193,059	22,162	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.179575	15,583	2,798	65.00
66.00	06600 PHYSICAL THERAPY	0.427309	418,880	178,991	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0.299777	0	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0.273935	0	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	0.315282	385,877	121,660	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0.306959	0	0	67.10
68.00	06800 SPEECH PATHOLOGY	0.310324	213,428	66,232	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0.283764	0	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.179008	4,719	845	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.232123	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.183312	585,555	107,339	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03020 RADIOLOGY	0.132644	3,099	411	76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0.000000	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	1.468103	0	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0.280881	0	0	90.50
91.00	09100 EMERGENCY	0.516742	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.356897	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,881,627	509,717	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,881,627		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/31/2023 11:28 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
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)		33,224,301	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		11,307,253	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)		1,600,750	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		243,974	2.04
3.00	Managed Care Simulated Payments		41,170,566	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		410.00	4.00
<b>Indirect Medical Education Adjustment</b>				
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)		16.76	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.		3.00	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)		19.76	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		27.25	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)		19.76	12.00
13.00	Total allowable FTE count for the prior year.		19.76	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.		19.76	14.00
15.00	Sum of lines 12 through 14 divided by 3.		19.76	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		19.76	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.048195	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.049874	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.048195	21.00
22.00	IME payment adjustment (see instructions)		1,157,019	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		1,069,694	22.01
<b>Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA</b>				
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)		7.49	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)		1,157,019	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		1,069,694	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		6.07	30.00
31.00	Percentage of Medicaid patient days (see instructions)		37.28	31.00
32.00	Sum of lines 30 and 31		43.35	32.00
33.00	Allowable disproportionate share percentage (see instructions)		24.98	33.00
34.00	Disproportionate share adjustment (see instructions)		2,780,996	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/31/2023 11:28 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
<b>Uncompensated Care Payment Adjustment</b>				
35.00	Total uncompensated care amount (see instructions)	7,192,008,710	6,874,403,459	35.00
35.01	Factor 3 (see instructions)	0.000401192	0.000482706	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	2,885,376	3,318,316	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	2,158,103	836,398	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	2,994,501		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>				
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)	53,308,794		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		48.00
		<b>Amount</b>		
		1.00		
49.00	Total payment for inpatient operating costs (see instructions)		54,378,488	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		3,990,592	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).		892,904	52.00
53.00	Nursing and Allied Health Managed Care payment		15,234	53.00
54.00	Special add-on payments for new technologies		427,274	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)		10,787	58.00
59.00	Total (sum of amounts on lines 49 through 58)		59,715,279	59.00
60.00	Primary payer payments		52,532	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		59,662,747	61.00
62.00	Deductibles billed to program beneficiaries		4,544,372	62.00
63.00	Coinurance billed to program beneficiaries		253,301	63.00
64.00	Allowable bad debts (see instructions)		144,169	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		93,710	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		69,836	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		54,958,784	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)		-100,986	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/31/2023 11:28 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	1.00	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			54,857,798	71.00
71.01	Sequestration adjustment (see instructions)			691,208	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
71.03	Sequestration adjustment-PARHM or CHART pass-throughs				71.03
72.00	Interim payments			53,672,010	72.00
72.01	Interim payments-PARHM or CHART				72.01
73.00	Tentative settlement (for contractor use only)			0	73.00
73.01	Tentative settlement-PARHM or CHART (for contractor use only)				73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			494,580	74.00
74.01	Balance due provider/program-PARHM or CHART (see instructions)				74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			1,017,258	75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. 1, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
<b>HSP Bonus Payment Amount</b>					
100.00	HSP bonus amount (see instructions)			0	100.00
<b>HVBP Adjustment for HSP Bonus Payment</b>					
101.00	HVBP adjustment factor (see instructions)			0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
<b>HRR Adjustment for HSP Bonus Payment</b>					
103.00	HRR adjustment factor (see instructions)			0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
<b>Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment</b>					
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
<b>Cost Reimbursement</b>					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. 11, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
<b>Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)</b>					
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
<b>Adjustment to Medicare Part A Inpatient Reimbursement</b>					
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
<b>Comparison of PPS versus Cost Reimbursement</b>					
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: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/31/2023 11:28 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		197	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		28,804,740	2.00
3.00	OPPS payments		28,349,842	3.00
4.00	Outlier payment (see instructions)		208,507	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		9,326	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		197	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		914	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)		914	14.00
<b>Customary charges</b>				
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)		914	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		717	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)		197	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)		28,567,675	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		128	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		4,682,529	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)		23,885,215	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		374,544	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)		24,259,759	30.00
31.00	Primary payer payments		13,925	31.00
32.00	Subtotal (line 30 minus line 31)		24,245,834	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		176,818	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		114,932	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		141,997	36.00
37.00	Subtotal (see instructions)		24,360,766	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-3,362	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)		24,364,128	40.00
40.01	Sequestration adjustment (see instructions)		306,988	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		24,149,106	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)		-91,966	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
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/31/2023 11:28 am
		Title XVIII	Hospital PPS
			1.00
200.00	MEDI CARE PART B ANCI LLARY COSTS Part B Combined Billed Days		0 200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0058

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/31/2023 11:28 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		53,672,010		24,149,106	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)		53,672,010		24,149,106	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		494,580		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		91,966	6.02	
7.00	Total Medicare program liability (see instructions)		54,166,590		24,057,140	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	



ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0058  
Component CCN: 15-T058

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/31/2023 11:28 am

Title XVIII

Subprovider -  
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					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		2,564,705		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)		2,564,705		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		37,131		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,601,836		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/31/2023 11:28 am
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
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
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0058 Component CCN: 15-T058	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part III Date/Time Prepared: 5/31/2023 11:28 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)			2,380,113 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0353 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			193,741 3.00
4.00	Outlier Payments			78,719 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			13.490411 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			2,652,573 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			2,652,573 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			2,652,573 19.00
20.00	Deductibles			9,366 20.00
21.00	Subtotal (line 19 minus line 20)			2,643,207 21.00
22.00	Coinsurance			8,169 22.00
23.00	Subtotal (line 21 minus line 22)			2,635,038 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			2,635,038 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.98	Recovery of accelerated depreciation.			0 31.98
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			2,635,038 32.00
32.01	Sequestration adjustment (see instructions)			33,202 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			2,564,705 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			37,131 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			78,719 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00
<b>FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE</b>				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.			0.000000 99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)			0.000000 99.01

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet E-4 Date/Time Prepared: 5/31/2023 11:28 am	
		Title XVIII	Hospital	PPS	
				1.00	
<b>COMPUTATION OF TOTAL DIRECT GME AMOUNT</b>					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			24.76	1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)			0.00	1.01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
2.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)				2.26
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)				3.02
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			3.00	4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)				4.21
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27)			27.76	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			27.25	6.00
7.00	Enter the lesser of line 5 or line 6			27.25	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	27.25	0.00	27.25	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.	27.25	0.00	27.25	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	27.25	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	27.16	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	27.24	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	27.22	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	27.22	0.00		17.00
18.00	Per resident amount	119,314.00	0.00		18.00
18.01	Per resident amount under §131 of the CAA 2021				18.01
19.00	Approved amount for resident costs	3,247,727	0	3,247,727	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			3,247,727	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet E-4 Date/Time Prepared: 5/31/2023 11:28 am
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		Title XVIII		Hospital	PPS
		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
<b>COMPUTATION OF PROGRAM PATIENT LOAD</b>					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	23,563	22,101		26.00
27.00	Total Inpatient Days (see instructions)	109,008	109,008		27.00
28.00	Ratio of inpatient days to total inpatient days	0.216158	0.202747		28.00
29.00	Program direct GME amount	702,022	658,467	1,360,489	29.00
29.01	Percent reduction for MA DGME				29.01
30.00	Reduction for direct GME payments for Medicare Advantage		93,041	93,041	30.00
31.00	Net Program direct GME amount			1,267,448	31.00
				1.00	
<b>DI RECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)</b>					
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
<b>APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY</b>					
<b>Part A Reasonable Cost</b>					
37.00	Reasonable cost (see instructions)			68,711,825	37.00
38.00	Organ acquisition and HSCT acquisition costs (see instructions)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			52,532	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			68,659,293	41.00
<b>Part B Reasonable Cost</b>					
42.00	Reasonable cost (see instructions)			28,814,263	42.00
43.00	Primary payer payments (see instructions)			13,925	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			28,800,338	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			97,459,631	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.704490	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.295510	47.00
<b>ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B</b>					
48.00	Total program GME payment (line 31)			1,267,448	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			892,904	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			374,544	50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet E-5 Date/Time Prepared: 5/31/2023 11:28 am
		Title XVIII		PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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. I, 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: 15-0058

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

Worksheet G  
Date/Time Prepared:  
5/31/2023 11:28 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	21,953,000	0	0	0	1.00
2.00	Temporary investments	15,941,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	269,370,000	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-152,375,000	0	0	0	6.00
7.00	Inventory	18,016,000	0	0	0	7.00
8.00	Prepaid expenses	963,000	0	0	0	8.00
9.00	Other current assets	42,055,000	0	0	0	9.00
10.00	Due from other funds	0	9,353,000	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	215,923,000	9,353,000	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	26,982,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	530,738,000	0	0	0	15.00
16.00	Accumulated depreciation	-476,619,000	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	255,015,000	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	336,116,000	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	30,484,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	30,484,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	582,523,000	9,353,000	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	50,943,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	5,320,000	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	2,980,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	59,243,000	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	173,397,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	173,397,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	232,640,000	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	349,883,000	0	0	0	52.00
53.00	Specific purpose fund	0	9,353,000	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	349,883,000	9,353,000	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	582,523,000	9,353,000	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0058

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

Worksheet G-1

Date/Time Prepared:  
5/31/2023 11:28 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		303,747,000		9,395,000		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		103,716,868				2.00
3.00	Total (sum of line 1 and line 2)		407,463,868		9,395,000		3.00
4.00	NET ASSETS RELEASED FROM RESTRICTION	1,390,000		0		0	4.00
5.00	CHANGE IN INTEREST IN RECIPIENT ORG	0		-42,000		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		1,390,000		-42,000		10.00
11.00	Subtotal (line 3 plus line 10)		408,853,868		9,353,000		11.00
12.00	NET ASSETS RELEASED AND TRANSFERRED	59,054,867		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)		59,054,867		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		349,799,001		9,353,000		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	NET ASSETS RELEASED FROM RESTRICTION		0				4.00
5.00	CHANGE IN INTEREST IN RECIPIENT ORG		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	NET ASSETS RELEASED AND TRANSFERRED		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: 15-0058

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/31/2023 11:28 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	280,738,216		280,738,216	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	15,243,763		15,243,763	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)	295,981,979		295,981,979	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	48,090,575		48,090,575	11.00
11.01	NEONATAL INTENSIVE CARE UNIT	29,808,678		29,808,678	11.01
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)	77,899,253		77,899,253	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	373,881,232		373,881,232	17.00
18.00	Ancillary services	766,172,757	698,779,969	1,464,952,726	18.00
19.00	Outpatient services	22,075,941	111,920,551	133,996,492	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NURSERY	5,804,230	0	5,804,230	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	1,167,934,160	810,700,520	1,978,634,680	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		570,038,249		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		570,038,249		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet G-3 Date/Time Prepared: 5/31/2023 11:28 am
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,978,634,680	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,347,165,132	2.00
3.00	Net patient revenues (line 1 minus line 2)	631,469,548	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	570,038,249	4.00
5.00	Net income from service to patients (line 3 minus line 4)	61,431,299	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	115,407	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	470,168	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,843,235	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	5,234,888	23.00
24.00	ALL OTHER INCOME	16,945,368	24.00
24.01	UNREALIZED GAINS ON SWAPS, NET	5,852,705	24.01
24.02	OTHER (SPECIFY)	0	24.02
24.50	COVID-19 PHE Funding	11,823,798	24.50
25.00	Total other income (sum of lines 6-24)	42,285,569	25.00
26.00	Total (line 5 plus line 25)	103,716,868	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)	103,716,868	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0058	Period: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III Date/Time Prepared: 5/31/2023 11:28 am
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		3,370,915	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		219,038	1.01
2.00	Capital DRG outlier payments		0	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)		285.16	3.00
4.00	Number of interns & residents (see instructions)		19.76	4.00
5.00	Indirect medical education percentage (see instructions)		1.98	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)		71,081	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		6.07	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		37.28	8.00
9.00	Sum of lines 7 and 8		43.35	9.00
10.00	Allowable disproportionate share percentage (see instructions)		9.18	10.00
11.00	Disproportionate share adjustment (see instructions)		329,558	11.00
12.00	Total prospective capital payments (see instructions)		3,990,592	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
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)		4.00	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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