This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 31-3300 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/25/2023 5:49 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/25/2023 5:49 pm ] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Initial Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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 CHILDRENS SPECIALIZED HOPSITAL (31-3300) 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			ELECTRONI C	
	1			SI GNATURE STATEMENT	
1	Richard Henwood			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	Ri chard Henwood			2
3	Signatory Title	VP OF CORPORATE REIMBURSEMENT			3
4	Date	(Dated when report is electronica			4

			Title XVIII				
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-3, 915	19, 622	0	-1, 480, 801	1. 00
2.00	SUBPROVI DER - I PF	0	0	0		0	2. 00
3.00	SUBPROVI DER - I RF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
8.00	NURSING FACILITY	0				0	8. 00
200.0	TOTAL	0	-3, 915	19, 622	0	-1, 480, 801	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: 31-3300 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/25/2023 5:49 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 150 PROVIDENCE ROAD 1.00 PO Box: 1.00 Zip Code: 07094 2.00 City: MOUNTAINSIDE State: NJ County: UNION 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 CHILDRENS SPECIALIZED 313300 35084 01/01/1970 Ν 3.00 HOPSI TAI Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6 00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF CHILDRENS SPECIALIZED 315239 35084 10/06/1986 Ρ Ν 9.00 HOSPI TAI 10.00 Hospi tal -Based NF CHILDRENS SPECIALIIZED 315239 35084 10/06/1986 N 10.00 N HOSPI TAI 11.00 Hospi tal -Based OLTC 11.00 Hospi tal -Based HHA 12.00 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 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) 21.00 1. 00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Ν Ν 22.00 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. Did this hospital receive interim UCPs, including supplemental UCPs, for Ν Ν 22.01 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) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 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. 22.03 Did this hospital receive a geographic reclassification from urban to N N Ν 22 03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23.00 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.

	with 42 CFR Section §412.320? (see instructions)				
46.	00   Is this facility eligible for additional payment exception for extraordinary circumstances	N	N	N	46. 00
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through				
	Pt. III.				
47.	00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47. 00
48.	00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48. 00
	Teaching Hospitals	•			1
56.	00 Is this a hospital involved in training residents in approved GME programs? For cost reporting	Υ	Υ		56. 00
	periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For				
	cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see				
	the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was				
	involved in training residents in approved GME programs in the prior year or penultimate year,				
	and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter				
	"Y" for yes; otherwise, enter "N" for no in column 2.				
57.	00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes,	Y	ĺ		57. 00
	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.				
58.	00   If line 56 is yes, did this facility elect cost reimbursement for physicians' services as	N			58. 00
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				
MCR	F32 - 19. 1. 175. 2				

	unweighted count. Enter in column 4, the direct GME					
	FTE unweighted count.					
61. 20	Of the FTEs in line 61.05, specify each expanded			0.00	0.00	61. 20
	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.					
					1. 00	
	ACA Provisions Affecting the Health Resources and Ser	rvices Administration	(HRSA)			
62.00	Enter the number of FTE residents that your hospital	trained in this cost	reporting peri	od for which	0.00	62.00
	your hospital received HRSA PCRE funding (see instruc	ctions)				
62.01	Enter the number of FTE residents that rotated from a	a Teaching Health Cent	ter (THC) into	your hospital	0.00	62. 01
	during in this cost reporting period of HRSA THC prog	gram. (see instruction	ns)	<u> </u>		
	Teaching Hospitals that Claim Residents in Nonprovide	er Settings				
63.00	Has your facility trained residents in nonprovider se	ettings during this co	st reporting p	eriod? Enter	N	63.00
	"Y" for yes or "N" for no in column 1. If yes, comple	ete lines 64 through 6	57. (see instru	ıcti ons)		
	· · · · · · · · · · · · · · · · · · ·	•				

Health Financial Systems	CHILDRENS	SPECIALIZED HOPSITA	AL.	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP			CCN: 31-3300	Peri od:	Worksheet S-2	
				From 01/01/2022 To 12/31/2022		
			Unwei ghted	Unwei ghted	Ratio (col. 1/	
			FTEs Nonprovider Site	FTEs in Hospital	(col. 1 + col. 2))	
			1.00	2. 00	3.00	-
Section 5504 of the ACA Base Ye	ar FTE Residents in N	onprovider Settings	_			
period that begins on or after 64.00 Enter in column 1, if line 63 i in the base year period, the nu resident FTEs attributable to r settings. Enter in column 2 th resident FTEs that trained in y	s yes, or your facili mber of unweighted no otations occurring in e number of unweighte our hospital. Enter i	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio		0. 00	0. 000000	64.00
of (column 1 divided by (column	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	,
	Trogram Name	Trogram code	FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
	1.00	2.00	3. 00	4.00	5. 00	1
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)			Unwei ghted FTES	Unwei ghted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der Si te	Hospi tal	2))	
			1. 00	2.00	3.00	1
Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovider Settir				
beginning on or after July 1, 2		<u> </u>				
66.00 Enter in column 1 the number of FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1	occurring in all nonpo unweighted non-primad tal. Enter in column :	rovider settings. ry care resident 3 the ratio of	0.0	3. 41	0. 000000	66. 00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
	1.00	2.00	Si te 3. 00	4.00	5. 00	-
67.00 Enter in column 1, the program	PEDI ATRI CS	2.00	3.00			67.00
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column						
4)). (see instructions) 67.01	FAMILY MEDICINE	1350	0.0	0. 00	1. 000000	67. 01
	p 21	150	0.0	5.00		, 57. 01

	Financial Systems CHILDRENS SPECIALIZED H			n Lieu	u of Form CMS-	
PI IAI	L AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Prov	/ider CCN: 31-3300	Period: From 01/01/ To 12/31/		Worksheet S-2 Part I Date/Time Pre 5/25/2023 5:4	epared
						+ 7 Pill
D	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 4	9065-49072 (August	10, 2022)		1. 00	
00 F	or a cost reporting period beginning prior to October 1, 2022, did IAC to apply the new DGME formula in accordance with the FY 2023 II August 10, 2022)?	d you obtain permi:	ssion from yo		Y	68. 0
				1. 00	2.00 3.00	
	<pre>npatient Psychiatric Facility PPS s this facility an Inpatient Psychiatric Facility (IPF), or does in</pre>	t contain an IPE	subprovi der?	N	<u> </u>	70. (
00 I r 4 p C	fline 70 is yes or "N" for no.  fline 70 is yes: Column 1: Did the facility have an approved GME recent cost report filed on or before November 15, 2004? Enter "Y' 2004? Ente	teaching program   ' for yes or "N" fo sidents in a new to ' for yes or "N" fo	in the most or no. (see eaching or no.		0	71. (
ì	npatient Rehabilitation Facility PPS					
	s this facility an Inpatient Rehabilitation Facility (IRF), or documentation subprovider? Enter "Y" for yes and "N" for no.	es it contain an II	₹⊦	N		75. (
r n C	fline 75 is yes: Column 1: Did the facility have an approved GME recent cost reporting period ending on or before November 15, 2004 to. Column 2: Did this facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility have an approved GME recent to the facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility train residents in a new teaching period of the facility trai	? Enter "Y" for ye: orogram in accorda n 3: If column 2 i:	s or "N" for nce with 42 s Y,		0	76.
					1. 00	+
	ong Term Care Hospital PPS					
00	s this a long term care hospital (LTCH)? Enter "Y" for yes and "Is this a LTCH co-located within another hospital for part or all of Y" for yes and "N" for no.  EFRA Providers		ing period? E	nter	N N	80. 81.
00 I 00 D	is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA is this facility establish a new Other subprovider (excluded unit; 413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			no.	N	85. 86.
00	1415.40(1)(11)? Enter it for yes and in for no. is this hospital an extended neoplastic disease care hospital class 886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	sified under secti	on		N	87.
			Approved Permand Adjustm (Y/N)	ent ient	Number of Approved Permanent Adjustments	
			1.00		2. 00	
a 8	column 1: Is this hospital approved for a permanent adjustment to a mount per discharge? Enter "Y" for yes or "N" for no. If yes, complete, (see instructions) column 2: Enter the number of approved permanent adjustments.		ine		(	0 88.
,			ne Effective	Date		
		No.			Permanent Adjustment Amount Per Discharge	
00 C	Column 1: If line 88, column 1 is Y, enter the Worksheet A line num	1.00	2. 00	)	3. 00	0 89.
o C b p	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 and per discharge. Column 3: Enter the amount of the approved permanent adjustment to	d mount	3. 65			
Т	EFRA target amount per discharge.		V		XI X	
			1.00		2. 00	
	itle V and XIX Services Does this facility have title V and/or XIX inpatient hospital servi	ces? Enter "Y" for	r N		Υ	90.
У	res or "N" for no in the applicable column.				Υ	91.
f OO A	s this hospital reimbursed for title V and/or XIX through the cosfull or in part? Enter "Y" for yes or "N" for no in the applicable are title XIX NF patients occupying title XVIII SNF beds (dual cert	column. tification)? (see	IN.		Y N	91.
	nstructions) Enter "Y" for yes or "N" for no in the applicable colloes this facility operate an ICF/IID facility for purposes of title		n N		N	93.
	Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N"		N		N	94.
			1			
00 D a	upplicable column.  fline 94 is "Y", enter the reduction percentage in the applicable	e column.	0.00		0. 00	95.
00 D a 00 I 00 D a	pplicable column.	'for no in the	0. 00 N 0. 00		0. 00 N 0. 00	95. 96. 97.

	title V or XIX follow Medicare (title XVIII) for a cri- bursed 101% of inpatient services cost? Enter "Y" for yo		N	N	98. 03	
98.04 Does outpa	title V, and in column 2 for title XIX. title V or XIX follow Medicare (title XVIII) for a CAH atient services cost? Enter "Y" for yes or "N" for no in		N	N	98. 04	
98.05 Does Wkst.	olumn 2 for title XIX. title V or XIX follow Medicare (title XVIII) and add ba C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in o nn 2 for title XIX.	N	Y	98. 05		
98.06 Does Pts. colum	title V or XIX follow Medicare (title XVIII) when cost I through IV? Enter "Y" for yes or "N" for no in column nn 2 for title XIX.			N	Y	98. 06
105. 00 Does	Providers this hospital qualify as a CAH?			N		105. 00
	nis facility qualifies as a CAH, has it elected the all- outpatient services? (see instructions)	hod of payment			106. 00	
trai n Col um appro	nn 1: If line 105 is Y, is this facility eligible for co ning programs? Enter "Y" for yes or "N" for no in column nn 2: If column 1 is Y and line 70 or line 75 is Y, do oved medical education program in the CAH's excluded II - "Y" for yes or "N" for no in column 2. (see instructi	n 1. (see ins <sup>.</sup> you train I&R: PF and/or IRF (	tructions) s in an			107. 00
108.00 Is th	nis a rural hospital qualifying for an exception to the Section §412.113(c). Enter "Y" for yes or "N" for no.		dul e? See 42	N		108. 00
•		Physi cal	Occupati onal	Speech	Respi ratory	
thera	nis hospital qualifies as a CAH or a cost provider, are appy services provided by outside supplier? Enter "Y" yes or "N" for no for each therapy.	1.00	2.00 N	3. 00 N	4. 00 N	109. 00
					1.00	_
Demon	this hospital participate in the Rural Community Hospitanstration)for the current cost reporting period? Enter ete Worksheet E, Part A, lines 200 through 218, and Wol	"Y" for yes or	"N" for no. If	yes,	N	110. 00
appl i	cabl e.					
				1. 00	2.00	
111.00 If th Healt "Y" f integ Enter	cable.  his facility qualifies as a CAH, did it participate in the Integration Project (FCHIP) demonstration for this coror yes or "N" for no in column 1. If the response to correction prong of the FCHIP demo in which this CAH is partiall that apply: "A" for Ambulance services; "B" for actele-health services.	ost reporting polumn 1 is Y, or rticipating in	period? Enter enter the column 2.	1. 00 N	2.00	111.00
111.00 If th Healt "Y" f integ Enter	nis facility qualifies as a CAH, did it participate in the Integration Project (FCHIP) demonstration for this cofor yes or "N" for no in column 1. If the response to cogration prong of the FCHIP demo in which this CAH is part all that apply: "A" for Ambulance services; "B" for a	ost reporting polumn 1 is Y, or rticipating in	period? Enter enter the column 2. ; and/or "C"	N		111.00
111.00   f th Heal t "Y" f integ Enter for t	nis facility qualifies as a CAH, did it participate in the Integration Project (FCHIP) demonstration for this compared or "N" for no in column 1. If the response to contain the property of the FCHIP demo in which this CAH is partically that apply: "A" for Ambulance services; "B" for actele-health services.  This hospital participate in the Pennsylvania Rural Heal (MM) demonstration for any portion of the current cost reports of the pennsylvania Rural Heal (MM) that is the pennsylvania Rural Heal (MM) demonstration for any portion of the current cost reports of the pennsylvania Rural Heal (MM) that is the pennsylvania Rural Heal (MM) that is the pennsylvania Rural Heal (MM) demonstration for any portion of the current cost reports of the pennsylvania Rural Heal (MM) that is the pennsylvania Rural Heal (MM)	ost reporting polumn 1 is Y, orticipating in dditional beds;  Ith Model eporting olumn 1 is pating in the ased	period? Enter enter the column 2.		3.00	112. 00
111.00 of the Heal to "Y" for the integration of the Heal to "Y" for the Heal to the Heal	nis facility qualifies as a CAH, did it participate in the Integration Project (FCHIP) demonstration for this conforce of the FCHIP demonstration for this conforce of the FCHIP demonstration for this capturation prong of the FCHIP demonstration that apply: "A" for Ambulance services; "B" for active ele-health services.  This hospital participate in the Pennsylvania Rural Heal MM) demonstration for any portion of the current cost reports of the cu	ost reporting polumn 1 is Y, orticipating in dditional beds;  Ith Model eporting olumn 1 is pating in the ased s and Rural	period? Enter enter the column 2. and/or "C"	N		
111.00 of the Heal to "Y" for integration in the Heal to "Y" for integration in the Heal to "Y", demon particular in the H	nis facility qualifies as a CAH, did it participate in the Integration Project (FCHIP) demonstration for this confort yes or "N" for no in column 1. If the response to congration prong of the FCHIP demo in which this CAH is participate in that apply: "A" for Ambulance services; "B" for active e-health services.  This hospital participate in the Pennsylvania Rural Heal MM) demonstration for any portion of the current cost reports of the current cost reports of the column 1. If conformation in column 2, the date the hospital began participate in the date the hospital conformation. In column 3, enter the date the hospital conformation in the demonstration, if applicable, this hospital participate in the Community Health Access formation (CHART) model for any portion of the current for ting period? Enter "Y" for yes or "N" for no.  The Ilaneous Cost Reporting Information is an all-inclusive rate provider? Enter "Y" for yes on the method used (A, Ilaneous Cost Reporting Information 1. If column 1 is yes, enter the method used (A, Ilaneous Cost Reporting Information 2. If column 2 is "E", enter in column 3 either "Short term hospital or "98" percent for long term care in atric, rehabilitation and long term hospitals provided.	ost reporting polumn 1 is Y, orticipating in dditional beds:  I th Model eporting olumn 1 is pating in the ased s and Rural cost  r "N" for no B, or E only) 93" percent (includes	period? Enter enter the column 2. and/or "C"	N		112. 00
111.00 or the definition of th	nis facility qualifies as a CAH, did it participate in the Integration Project (FCHIP) demonstration for this capture of the Integration Project (FCHIP) demonstration for this capture of the FCHIP demo in which this CAH is pair all that apply: "A" for Ambulance services; "B" for actele-health services.  This hospital participate in the Pennsylvania Rural Health demonstration for any portion of the current cost read? Enter "Y" for yes or "N" for no in column 1. If content in column 2, the date the hospital began participate in the date the hospital content in column 3, enter the date the hospital content in the demonstration, if applicable, this hospital participate in the Community Health Accession of CHART) model for any portion of the current ting period? Enter "Y" for yes or "N" for no. Bellaneous Cost Reporting Information  This an all-inclusive rate provider? Enter "Y" for yes on the column 1 is yes, enter the method used (A, Information 1. If column 1 is yes, enter the method used (A, Information 2 is "E", enter in column 3 either "Oshort term hospital or "98" percent for long term care in atric, rehabilitation and long term hospitals provided definition in CMS Pub. 15-1, chapter 22, §2208. 1.  This facility classified as a referral center? Enter "Y"	ost reporting polumn 1 is Y, or ticipating in dditional beds;  Ith Model eporting olumn 1 is pating in the ased s and Rural cost  ""N" for no B, or E only) 93" percent (includes rs) based on	period? Enter enter the column 2. and/or "C"	N		112. 00
111.00 or the data of the data	nis facility qualifies as a CAH, did it participate in the Integration Project (FCHIP) demonstration for this compared or "N" for no in column 1. If the response to contain that apply: "A" for Ambulance services; "B" for actele-health services.  This hospital participate in the Pennsylvania Rural Health (M) demonstration for any portion of the current cost reports of the current cost in the current cost in the current cost of the current	ost reporting polumn 1 is Y, or ticipating in dditional beds:  Ith Model eporting olumn 1 is pating in the ased  s and Rural cost  r "N" for no B, or E only) 93" percent (includes rs) based on	period? Enterenter the column 2. and/or "C"  1.00  N	N		112. 00 113. 00 0 115. 00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der Co	CN: 31-3300	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S Part I Date/Time F 5/25/2023 S	Prepared:
		Premi ums	Losses	Insurance	
		1. 00	2.00	3. 00	$\dashv$
18.01 List amounts of malpractice premiums and paid losses:		485, 7	26 0		0 118. 0
			4.00	0.00	
18.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.  19.00 D0 NOT USE THIS LINE			1. 00 N	2.00	118. 0
20.00 s this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y alifies for t	" for yes or he Outpatient		Y	120. 0
21.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	ntable device	s charged to	N		121. 0
22.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.					122. 0
23.00 Did the facility and/or its subproviders (if applicable) purservices, e.g., legal, accounting, tax preparation, bookkeep management/consulting services, from an unrelated organization for yes or "N" for no. <pre>If column 1 is "Y", were the majority of the expenses, i.e., professional services expenses, for services purchased from located in a CBSA outside of the main hospital CBSA? In column "N" for no.</pre>	ing, payroll, on? In column greater than unrelated org	and/or 1, enter "Y" 50% of total ani zati ons			123. C
Certified Transplant Center Information 25.00 Does this facility operate a Medicare-certified transplant c	enter? Enter	"Y" for ves	N		125. 0
and "N" for no. If yes, enter certification date(s) (mm/dd/y 26.00 f this is a Medicare-certified kidney transplant program, e	yyy) below.	,			126. 0
in column 1 and termination date, if applicable, in column 2 27.00 f this is a Medicare-certified heart transplant program, en					127. 0
in column 1 and termination date, if applicable, in column 2 28.00 f this is a Medicare-certified liver transplant program, en	ter the certi	fication date			128. (
in column 1 and termination date, if applicable, in column 2 29.00 If this is a Medicare-certified lung transplant program, ent	er the certif	ication date			129. (
in column 1 and termination date, if applicable, in column 2 30.00 on this is a Medicare-certified pancreas transplant program,	enter the ce	rti fi cati on			130. (
date in column 1 and termination date, if applicable, in col 31.00  If this is a Medicare-certified intestinal transplant progra	m, enter the	certi fi cati on			131.
date in column 1 and termination date, if applicable, in col 32.00  If this is a Medicare-certified islet transplant program, en	ter the certi	fication date			132.
in column 1 and termination date, if applicable, in column 2 33.00 Removed and reserved 34.00 If this is a hospital-based organ procurement organization (in column 1 and termination date, if applicable, in column 2	OPO), enter t	he OPO number			133. ( 134. (
All Providers	•				
40.00 Are there any related organization or home office costs as d chapter 10? Enter "Y" for yes or "N" for no in column 1. If are claimed, enter in column 2 the home office chain number.	yes, and home (see instruc	office costs		H53560	140. (
1.00 2.00  If this facility is part of a chain organization, enter on I home office and enter the home office contractor name and co	ines 141 thro		3.00 name and address	of the	
41.00 Name: RWJBARNABAS HEALTH Contractor's Name: NOV			or's Number: 1200	1	141.
42.00 Street: 95 OLD SHORT HILLS   PO Box: 43.00 City: WEST ORANGE   State: NJ		Zi p Code	: 0705	2	142. ( 143. (
				1.00	
44.00 Are provider based physicians' costs included in Worksheet A	?			1. 00 Y	144. (
Sp. 1 p. 67. 46. 20004 p. jo. 6. 4.10 00010 The word The work Shock h				'	
25 001 0			1. 00	2. 00	
45.00 If costs for renal services are claimed on Wkst. A, line 74, inpatient services only? Enter "Y" for yes or "N" for no in no, does the dialysis facility include Medicare utilization period? Enter "Y" for yes or "N" for no in column 2.	column 1. If	column 1 is			145.
46.00 Has the cost allocation methodology changed from the previou Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 1			N		146.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der			eriod: rom 01/01/2022 o 12/31/2022		repared:
						1.00	_
147.00 Was there a change in the statisti	cal basis? Enter "Y" f	or yes or "N" f	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 simplifi	ed cost finding method	l? Enter "Y" for	yes or "N"	for n		N	149. 00
		Part A	Part		Title V	Title XIX	
		1.00	2.0		3.00	4. 00	
Does this facility contain a provi							
or charges? Enter "Y" for yes or '	N for no for each con	nponent for Par	t A and Par	t B. (3	See 42 CFR 941.	3. 13) N	155, 00
156. 00 Subprovi der – TPF		N N	N N		N N	N N	156. 00
157. 00 Subprovider - TRF		N N	N N		N N	N N	157. 00
158. OO SUBPROVI DER		IV.	l N		IN IN	IN IN	158. 00
159. 00 SNF		N	l N		l N	N	159. 00
160. 00 HOME HEALTH AGENCY		N	l N		l N	N N	160.00
161. 00 CMHC		"	l N		l N	N N	161. 00
							1
						1.00	
Mul ti campus							
165.00 Is this hospital part of a Multica	mpus hospital that has	one or more ca	ampuses in c	li ffere	ent CBSAs?	N	165. 00
Enter "Y" for yes or "N" for no.				1			
	Name	County	State		Code CBSA	FTE/Campus	_
166.00 If line 165 is yes, for each	0	1. 00	2. 00	3.	00 4.00	5. 00	00 166. 00
campus enter the name in column O, 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.	00 100. 00
						1.00	_
Health Information Technology (HI	) incentive in the Ame	rican Recovery	and Reinves	stment	Δct	1.00	
167.00 s this provider a meaningful user					ACC	N	167, 00
168.00 If this provider is a CAH (line 10					enter the		168. 00
reasonable cost incurred for the H				, .			
168.01 If this provider is a CAH and is r					hardshi p		168. 01
exception under §413.70(a)(6)(ii)?							
169.00 If this provider is a meaningful u		and is not a CA	AH (line 105	is "N	l"), enter the	0.	00 169. 00
transition factor. (see instruction	ons)						
					Begi nni ng	Endi ng	_
170.00 Enter in columns 1 and 2 the EHR k	sainning data and andi	na doto for the	- ronontina		1. 00	2.00	170.00
period respectively (mm/dd/yyyy)	egrinning date and endi	ng date for the	e reporting				170. 00
					1. 00	2.00	
171.00  fline 167 is "Y", does this prov	ider have any days for	individuals or	rolled in		1. 00 N	2.00	0 171. 00
section 1876 Medicare cost plans r "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	eported on Wkst. S-3, umn 1. If column 1 is y	Pt. I, line 2,	col. 6? Ent		IN IN		0171.00

Heal th	Financial Systems CHILDRENS SPECIA	ALIZED HOPSITAL	<u>.</u>	In Lie	eu of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 31-3300	Peri od: From 01/01/2022	Worksheet S-2	
				To 12/31/2022	Date/Time Pre	
				Y/N	5/25/2023 5: 4 Date	19 pm
				1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in	the	
1 00	Provider Organization and Operation	- h!! <i>-</i>	46	N	T	1 00
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a					1.00
			Y/N	Date	V/I	
2. 00	Has the provider terminated participation in the Medicare F	Program? If	1.00 N	2. 00	3. 00	2.00
3.00	yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.  Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	mn 3, "V" for ng management offices, drug der or its of the board	N			3. 00
	Trefationships: (see matraetrons)		Y/N	Туре	Date	
	Financial Data and Dananta		1.00	2. 00	3. 00	
4. 00 5. 00	Financial Data and Reports  Column 1: Were the financial statements prepared by a Cerraccountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date avaccolumn 3. (see instructions) If no, see instructions.  Are the cost report total expenses and total revenues difference.	for Compiled, ailable in	Y	A	04/07/2023	4. 00
5.00	those on the filed financial statements? If yes, submit rec		IN.			3.00
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
6.00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, is	the provide	r N		6. 00
7. 00 8. 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve		ved during th	e N		7. 00 8. 00
9. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	•	cal education	N		9. 00
10. 00	program in the current cost report? If yes, see instruction was an approved Internal and Resident GME program initiated of		he current	N		10.00
11. 00	cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	I & R in an App	proved	Y		11. 00
					1. 00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	N N	12. 00 13. 00
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsuralinstructions.	ance amounts wa	nived? If yes	, see	N	14. 00
15. 00	Bed Complement Did total beds available change from the prior cost reporti	ing period? If	ves. see ins	tructions	N	15. 00
10.00	The total bods available change from the prior cost reports		t A		t B	10.00
	PS&R Data	Y/N 1.00	Date 2.00	Y/N 3. 00	Date 4.00	
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/28/2023	Y	03/28/2023	16. 00
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17. 00
	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
18. 00	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.					

Heal th	Financial Systems CHILDRENS SPECIA	LIZED HOPSITAL	_	In Lie	u of Form CM	S-2552-10	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 31-3300	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S Part II Date/Time P 5/25/2023 5	repared:	
		Descr	i pti on	Y/N	Y/N		
	10.11		0	1.00	3. 00	00.00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00	
		Y/N	Date	Y/N	Date		
		1.00	2. 00	3. 00	4. 00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	HOSPI TALS)				
	Capital Related Cost						
22.00	Have assets been relifed for Medicare purposes? If yes, see	instructions			N	22. 00	
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		sals made dur	ing the cost	N	23. 00	
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost re	porting period?	N	24. 00	
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	rting period?	If yes, see	N	25. 00	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	e cost reporti	ng period? I	f yes, see	N	26. 00	
27. 00	Has the provider's capitalization policy changed during the copy.	cost reportin	ng period? If	yes, submit	N	27. 00	
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	itered into dui	ing the cost	reporting	N	28. 00	
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	bond funds (De	ebt Service R	eserve Fund)	N	29. 00	
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt? If yes	, see	N	30. 00	
31. 00	instructions. Has debt been recalled before scheduled maturity without is	suance of new	debt? If yes	, see	N	31. 00	
	instructions. Purchased Services						
32. 00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		ed through co	ntractual	N	32. 00	
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competi	tive bidding? If		33. 00	
	Provi der-Based Physi ci ans						
34. 00	Were services furnished at the provider facility under an a lf yes, see instructions.	ırrangement wi	th provider-b	ased physicians?	N	34. 00	
35. 00	If line 34 is yes, were there new agreements or amended exilphysicians during the cost reporting period? If yes, see in		nts with the	provi der-based		35. 00	
	phrysicians during the cost reporting period: it yes, see in	istructions.		Y/N	Date		
				1. 00	2. 00		
	Home Office Costs						
36. 00	Were home office costs claimed on the cost report?			Y		36. 00	
37. 00	If line 36 is yes, has a home office cost statement been pr	epared by the	home office?	Y		37. 00	
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off	ice different	from that of	N		38. 00	
39. 00	the provider? If yes, enter in column 2 the fiscal year end	of the home of	offi ce.			39. 00	
40. 00	see instructions.  If line 36 is yes, did the provider render services to the	•	,	, N		40. 00	
70.00	instructions.	nome office!	yes, see	IN		+0.00	
	1.00 2						
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RI CHARD		HENWOOD		41. 00	
42. 00		RWJBARNABAS HE	EALTH			42. 00	
43. 00		732 923-8074		RI CH. HENWOOD@R\	VJBH. ORG	43. 00	
	report preparer in columns 1 and 2, respectively.	l		I		II	

Heal th	Financial Systems	LIZED HOPSITA	L	In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT Q	DUESTI ONNAI RE	Provi der (		Peri od:	Worksheet S-2	
					From 01/01/2022 To 12/31/2022	Part II   Date/Time Pre   5/25/2023 5:4	pared: 9 pm
			3	. 00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the tit	tle/position	VP CORPORATE	REI MBURSEMENT			41. 00
	held by the cost report preparer in columns	s 1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost	t report					42. 00
	preparer.						
43.00	Enter the telephone number and email address	ss of the cost					43.00
	report preparer in columns 1 and 2, respect	ti vel y.					

 
 Heal th Financial
 Systems
 CHILDRENS

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA
 Provider CCN: 31-3300

					To	12/31/2022	Date/Time Prep 5/25/2023 5:49	
							I/P Days / 0/P	7 DIII
							Visits / Trips	
	Component	Worksheet A Line No.	No. of Be	eds	Bed Days Available	CAH Hours	Title V	
		1. 00	2. 00		3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		68	24, 820	0. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO I PF Subprovi der							3. 00
4.00	HMO I RF Subprovi der							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			68	24, 820	0. 00	0	7. 00
0.00	beds) (see instructions)							0.00
8.00	INTENSIVE CARE UNIT							8. 00 9. 00
9.00	CORONARY CARE UNIT							
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
13. 00 14. 00	NURSERY			4.0	24 020	0.00		14. 00
15. 00	Total (see instructions) CAH visits			68	24, 820	0. 00	0	15. 00
16. 00	SUBPROVIDER - IPF						U	16. 00
17. 00	SUBPROVIDER - IPF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY	44. 00		46	16, 790		0	19. 00
20.00	NURSING FACILITY	45. 00		26			0	20.00
21. 00	OTHER LONG TERM CARE	45.00		20	7, 470		U	21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )							23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC	50.00						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)	071.00		140			, and the second se	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)			o	o			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
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

 
 Heal th Financial
 Systems
 CHILDRENS

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA
 | Peri od: | Worksheet S-3 | From 01/01/2022 | Part I | To 12/31/2022 | Date/Time Prepared: Provider CCN: 31-3300

				'	0 12/31/2022	5/25/2023 5: 4	
		I/P Days	6 / O/P Visits	/ Tri ps	Full Time	Equi val ents	) piii
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	29	1, 989	19, 973			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)		7 (00				
2.00	HMO and other (see instructions)	0	7, 602				2.00
3.00	HMO I PF Subprovi der	0	0	1			3.00
4.00	HMO I RF Subprovi der	U	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	U	0				5.00
6.00	Hospital Adults & Peds. Swing Bed NF	29	0				6. 00 7. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	29	1, 989	19, 973			7.00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	29	1, 989	19, 973	5. 97	1, 089. 98	•
15. 00	CAH visits	27	1, 707	17, 775	3.77	1,007.70	15. 00
16. 00	SUBPROVIDER - I PF	Ĭ	ŭ				16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	o	15, 778	16, 133	0.00	115. 82	•
20.00	NURSING FACILITY		7, 096				1
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	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			C			24. 10
25. 00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C		0.00	
27. 00	Total (sum of lines 14-26)				5. 97	1, 205. 80	1
28. 00	Observation Bed Days		0	0			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30. 00	Employee discount days (see instruction)			C			30. 00
31. 00	Employee discount days - IRF			C			31. 00
32. 00	Labor & delivery days (see instructions)	0	0	C			32. 00
32. 01	Total ancillary labor & delivery room			C			32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days	0					33.00
33. 01	LTCH site neutral days and discharges	0	0	,			33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	0	0	[ C			34. 00

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | 
 Heal th Financial
 Systems
 CHILDRENS

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA
 Provider CCN: 31-3300

				11	0 12/31/2022	5/25/2023 5:4	
		Full Time		Di sch	arges	0,20,2020 0. 1	, p
		Equi val ents			3		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	·	Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	2	30	525	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)			_			
2.00	HMO and other (see instructions)			0	202		2. 00
3.00	HMO I PF Subprovi der				0		3. 00
4.00	HMO I RF Subprovi der				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF						6. 00 7. 00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	0	2	30	525	
15. 00	CAH visits						15. 00
16.00	SUBPROVIDER - IPF						16. 00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY	0.00					19. 00
20.00	NURSING FACILITY	0.00					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	HOSPI CE						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 29. 00	Observation Bed Days						28. 00 29. 00
30.00	Ambulance Trips						30.00
31. 00	Employee discount days (see instruction) Employee discount days - IRF						30.00
31.00	Labor & delivery days (see instructions)						31.00
32. 00	Total ancillary labor & delivery room						32. 00
JZ. UI	outpatient days (see instructions)						JZ. U1
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
	Temporary Expansion COVID-19 PHE Acute Care						34. 00
	, , ,	'		'	'	1	•

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | 5/25/2023 5:49 pm

							5/25/2023 5: 4	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	Adj usted Sal ari es (col . 2 ± col .	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
				A-6)	3)	col. 4	,	
	PART II - WAGE DATA	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	
	SALARI ES							
1. 00	Total salaries (see	200. 00	101, 173, 351	0	101, 173, 351	0. 00	0.00	1.0
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2.0
3.00	Non-physician anesthetist Part		0	0	0	0.00	0. 00	3.0
4. 00	B Physician-Part A -		0	0	0	0. 00	0. 00	4.0
4. 01	Administrative Physicians - Part A - Teaching		0	0	0	0.00	l .	
5.00	Physician and Non Physician-Part B		0	0	0	0.00		
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0. 00	0.00	6.0
7. 00	services Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7.0
7. 01	approved program) Contracted interns and residents (in an approved		0	0	0	0.00	0.00	7.0
8. 00	programs) Home office and/or related		0	0	0	0. 00	0. 00	8.0
9.00	organization personnel SNF	44. 00	6, 396, 558		7, 571, 909	0.00	l .	
10. 00	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS		4, 393, 244	270, 128	4, 663, 372	0. 00	0.00	10.0
11. 00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	11.0
12. 00	Contract Labor: Top Level management and other		0	0	0	0.00	0.00	12.0
13. 00	management and administrative services Contract labor: Physician-Part		0	0	0	0.00	0.00	13.0
14. 00	A - Administrative Home office and/or related		0	0		0.00		
11.00	organization salaries and wage-related costs		Ŭ			0.00	0.00	11.0
14. 01	Home office salaries		5, 358, 137	0	5, 358, 137	108, 759. 66		14. (
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00	l .	14. ( 15. (
16. 00	- Administrative Home office and Contract		0	0	0	0.00	0. 00	16. (
16. 01	Physicians Part A - Teaching Home office Physicians Part A		0	0	0	0.00	0.00	16. (
16. 02	- Teaching Home office contract		0	0	0	0.00	0.00	16. (
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see instructions)		0	0	0			17. (
18. 00	Wage-related costs (other) (see instructions)							18. 0
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		0	0 0	0 0			19. ( 20. (
21. 00	A Non-physician anesthetist Part		0	0	0			21.
22. 00	B Physician Part A -		0	0	0			22. (
22. 01	Administrative Physician Part A - Teaching		0	0	0			22.
23. 00	Physician Part B		0	0	0			23.
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0		0			24. 25.
25. 50	approved program) Home office wage-related		1, 186, 871	0	1, 186, 871			25.
25. 51	(core) Related organization		0	0	0			25.
25. 52	wage-related (core) Home office: Physician Part A		0	0	0			25. !
	- Administrative - wage-related (core)							

						3 12/31/2022	5/25/2023 5: 4	9 pm
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
	1	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
27 00	OVERHEAD COSTS - DIRECT SALARII		0.47 000	1 (70 007	022 014	0.00	0.00	27 00
26.00	Employee Benefits Department	4.00	846, 823					26. 00
27. 00	Administrative & General	5. 00	17, 053, 431	-2, 595, 016	14, 458, 415	0.00		
28. 00	Administrative & General under contract (see inst.)		Ü	0	0	0.00	0.00	28. 00
29. 00	Maintenance & Repairs	6. 00	0		0	0.00	0.00	29. 00
30.00	Operation of Plant	7. 00	2, 318, 681	8, 920	2, 327, 601	0.00		30.00
31. 00	Laundry & Linen Service	8. 00	2, 310, 001	0, 720	2, 327, 001	0.00		
32. 00	Housekeepi ng	9. 00	1, 401, 266	4, 460	1, 405, 726	0.00		
33. 00	Housekeeping under contract	7.00	1, 401, 200	1, 400	1, 403, 720	0.00		33. 00
00.00	(see instructions)		O		Ĭ	0.00	0.00	00.00
34.00	Di etary	10. 00	1, 219, 692	17, 880	1, 237, 572	0.00	0.00	34.00
35. 00	Di etary under contract (see		0	0	0	0.00	l .	
	instructions)							
36.00	Cafeteri a	11. 00	0	0	0	0.00	0.00	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37. 00
38. 00	Nursing Administration	13. 00	1, 065, 423	-1, 046, 207	19, 216	0.00	0. 00	38. 00
39.00	Central Services and Supply	14. 00	0	0	0	0.00	0.00	39. 00
40.00	Pharmacy	15. 00	1, 605, 061	-113, 613	1, 491, 448	0.00	0. 00	40. 00
41.00	Medical Records & Medical	16. 00	883, 335	4, 460	887, 795	0.00	0. 00	41.00
	Records Library							
42. 00	Social Service	17. 00	683, 891					42.00
43. 00	Other General Service	18. 00	464, 362	-450, 982	13, 380	0. 00	0.00	43. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 31-3300 Peri od:

						rom 01/01/2022 o 12/31/2022	Date/Time Prep	
		Worksheet A	Amount	Reclassi fi cati	Adiusted	Pai d Hours	5/25/2023 5: 49	9 pm
		Line Number	Reported	on of Salaries	.,		Average Hourly Wage (col. 4 ÷	
		Little Nulliber	керог геа	(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	`	col. 4	(01. 5)	
		1, 00	2.00	3.00	4, 00	5, 00	6, 00	
	PART III - HOSPITAL WAGE INDEX		2,00	0.00	11.00	0.00	0.00	
1.00	Net salaries (see		101, 173, 351	0	101, 173, 351	0.00	0.00	1. 00
	instructions)							
2.00	Excluded area salaries (see		10, 789, 802	1, 445, 479	12, 235, 281	0.00	0.00	2.00
	instructions)							
3.00	Subtotal salaries (line 1		90, 383, 549	-1, 445, 479	88, 938, 070	0.00	0.00	3.00
	minus line 2)							
4.00	Subtotal other wages & related		5, 358, 137	0	5, 358, 137	108, 759. 66	49. 27	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		1, 186, 871	0	1, 186, 871	0.00	1. 33	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		96, 928, 557	-1, 445, 479	95, 483, 078	108, 759. 66	877. 93	6.00
7.00	Total overhead cost (see		27, 541, 965	-6, 419, 900	21, 122, 065	0.00	0.00	7.00
	instructions)							

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2022 | Part IV | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 |

	10 12/31/2022	5/25/2023 5: 49	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Empl oyer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	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	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	o	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	o	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	o	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Noncumulative portion)		
	TAXES		
17. 00	FICA-Employers Portion Only	0	17.00
18. 00	Medicare Taxes - Employers Portion Only	0	
19. 00	Unempl oyment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21.00
	instructions))		
22. 00	Day Care Cost and Allowances	0	
		0	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	0	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	l	25. 00

		HILDRENS SPECIAL			In Lie	eu of Form CMS-2	<u> 2552-10</u>
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO		eri od:	Worksheet A	
					rom 01/01/2022		
				T	o 12/31/2022	Date/Time Pre	pared:
						5/25/2023 5: 4	9 pm
	Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col . 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		8, 556, 185	8, 556, 185	-3, 371, 163	5, 185, 022	1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0	0			
3.00	00300 OTHER CAP REL COSTS		0	0	0	0	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	846, 823	23, 113, 619				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	17, 053, 431	26, 924, 303	43, 977, 734	-2, 390, 257	41, 587, 477	5. 00
7.00	00700 OPERATION OF PLANT	2, 318, 681	2, 532, 225	4, 850, 906	10, 613	4, 861, 519	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	ol	0	0	0	0	8. 00
9.00	00900 HOUSEKEEPI NG	1, 401, 266	725, 726	2, 126, 992	5, 684	2, 132, 676	
10. 00	01000 DI ETARY	1, 219, 692	952, 138				
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 065, 423	19, 738				
15. 00	01500 PHARMACY	1, 605, 061	195, 546				
16.00	01600 MEDICAL RECORDS & LIBRARY	883, 335	197, 061	1, 080, 396	5, 001	1, 085, 397	16. 00
17.00	01700 SOCIAL SERVICE	683, 891	5, 558	689, 449	-567, 533	121, 916	17. 00
18.00	01080 I NSERVI CE EDUCATI ON	464, 362	56, 476	520, 838	-492, 887	27, 951	18. 00
21. 00	02100   &R SERVICES-SALARY & FRINGES APPRV	0	0		0		21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	٥	977, 413	977, 413			
22.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	U U	7/1, 413	7/1,413	U U	7/1, 413	22.00
		45.045.404	75.4.000	1 4/ /00 /07	0.004.470	10 (07 005	
30. 00	03000 ADULTS & PEDIATRICS	15, 845, 684	754, 923				30. 00
44. 00	04400 SKILLED NURSING FACILITY	6, 396, 558	458, 138				
45.00	04500 NURSING FACILITY	3, 445, 735	896, 816	4, 342, 551	468, 819	4, 811, 370	45. 00
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	5, 212	5, 212	. 0	5, 212	54.00
60.00	06000 LABORATORY	o	31, 601	31, 601	0	31, 601	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	ol	. 0		0	0	62. 30
65. 00	06500 RESPIRATORY THERAPY	2, 543, 916	1, 013, 467	3, 557, 383	50, 024		65. 00
66. 00	06600 PHYSI CAL THERAPY	4, 224, 454	155, 685			5, 470, 856	
	06700 OCCUPATI ONAL THERAPY	4, 947, 338	108, 949				
67.00			•				
68. 00	06800 SPEECH PATHOLOGY	5, 346, 635	651, 655				
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 715, 377			2, 715, 377	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	689, 507	689, 507	0	689, 507	73. 00
76.00	03550 MEDI CAL SERVI CES	9, 268, 040	723, 651	9, 991, 691	-4, 583, 446	5, 408, 245	76. 00
76. 01	03950 PSYCHI ATRI C	5, 366, 051	282, 516	5, 648, 567	1, 794, 512	7, 443, 079	76. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	. 0	1	0	l ol	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	ام	0	١	o o	0	76. 98
76. 79	07699 LI THOTRI PSY		0			Ö	76. 99
		0	0				
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	UU	0	0	ı U	0	77. 00
	OUTPATIENT SERVICE COST CENTERS	- 450 ossi	444.044	· · ·		10.510.404	
90. 00	09000 CLI NI C	5, 458, 355	464, 314	5, 922, 669	4, 620, 022	10, 542, 691	90. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
93. 00	04950 SCHOOL BASED PROGRAMS	9, 841, 111	287, 395	10, 128, 506	759, 472	10, 887, 978	93. 00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93. 99
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS			•			
113 00	11300 I NTEREST EXPENSE		1, 567, 033	1, 567, 033	-1, 567, 033	0	113. 00
118.00		100, 225, 842	75, 062, 227				
1 10.00	NONREI MBURSABLE COST CENTERS	100, 223, 042	13,002,221	173, 200, 007	-23, 412	173, 204, 037	1.10.00
101 00		047 500	1 071 0/0	2 010 470	22 442	2, 042, 890	101 00
	19100 RESEARCH	947, 509	1, 071, 969	2, 019, 478			
	07950 CHILD CARE CENTER (MEDICAL DAY CARE	0	0	1 477 007 517	0		194. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	101, 173, 351	76, 134, 196	177, 307, 547	0	177, 307, 547	200.00

Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/25/2023 5:49 pm

ENREAL SERVICE COST CINTERS   Service COST CINTERS					5/25/2023 5:4	49 pm
SERICRAL_SERVICE_COST_CENTERS	Cost Cen	ter Description				
ENPRAIL SERVICE COST CENTRES   1.00   0.00						
1.00			6.00	7.00		
2.00			1	E 40E 000	I	4
3.00   0.0300   OTHER CAP REL COSTS   0   0   0   0   0   0   0   0   0					•	
4.00   OOKOO   EMPLOYEE BENEFITS DEPARTMENT			1	1, 431, 610		
5.00   00500   ADMINISTRATIVE & GENERAL   2, 685, 233   44, 272, 710   5.00   7.00   00700   OPERATIN ON PLANT   -300, 537   4, 500, 892   7.00   8.00   0.0000   LAINDRY & LINEN SERVICE   0   0   2, 132, 676   9.00   0.0000   HOUSEKEEPING   0   2, 132, 676   9.00   0.0000   HOUSEKEEPING   0   2, 132, 676   9.00   0.0000   HUSEKEEPING   0   44, 216   13.00   13.00   1300, MURSI MS ADMINISTRATION   0   44, 216   15.00   15.00   15.00   MURSI MS ADMINISTRATION   0   44, 216   15.00   15.00   MUSI MS ADMINISTRATION   0   1, 704, 554   15.00   17.00   18.5 SERVI CES - SALARY & FRI NGES APPRV   0   0   77, 911   18.00   10.00   10.00   18.7 SERVI CES - SALARY & FRI NGES APPRV   0   977, 413   22.00   0.00   20.00   18.7 SERVI CES - SALARY & FRI NGES APPRV   0   977, 413   22.00   0.00   20.00   18.7 SERVI CES - SALARY & FRI NGES APPRV   0   977, 413   22.00   0.00   20.00   18.7 SERVI CES - SALARY & FRI NGES APPRV   0   977, 413   22.00   0.00   18.7 SERVI CES - SALARY & FRI NGES APPRV   0   977, 413   22.00   0.00   18.7 SERVI CES - SALARY & FRI NGES APPRV   0   977, 413   22.00   0.00   18.7 SERVI CES - SALARY & FRI NGES APPRV   0   977, 413   22.00   0.00   18.7 SERVI CES - SALARY & FRI NGES APPRV   0   977, 413   22.00   0.			1	0		
7, 00         007000   OPERATION OF PLANT         -300, 537   4, 560, 982           7, 00           9, 00         00900   HOUSEKEPING         0         2, 132, 676           9, 00           10, 00         01000   DI FIARY         -134, 185           2, 056, 283           10, 00           13, 00         01300   NURSING ADMINISTRATION         0         44, 216           13, 00           16, 00         01600   MEDICAL RECORDS & LIBRARY         -52, 931           1, 032, 466           16, 00           16, 00         01600   MEDICAL RECORDS & LIBRARY         -52, 931           1, 032, 466           16, 00           18, 00         01600   IAS ERVICES EDUCATION           0         27, 951           18, 00           18, 00         01600   IAS ERVICES-SALLARY & FRINGES APPRV           0         0         0         21, 00           22, 00         02200   IAS SERVICES-OTHER PRGU COSTS APPRV           0         0         0         27, 951           18, 00           30, 00         03000   ADULTS & PEDI ATRIC S         -731, 082           17, 876, 203           30, 00         44, 811, 370           45, 00           45, 00         0400   ADULTS & PEDI ATRIC S         -731, 082           17, 876, 203           30, 00         44, 811, 370           45, 00           45, 00						
0.000   0.0000   LAUNDRY & LINEN SERVICE   0   0   0.000   0.000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000000						
9.00   000000   HOUSEKEEPING						
10.00   01000   0150			1	-	l control of the cont	
13.00   01300   NURSING ADMINISTRATION   0   44, 216   15.00   15.00   15.00   15.00   16.00   PHARMACY   0   1, 704, 554   15.00   16.00   16.00   PHARMACY   0   1, 704, 554   15.00   16.00   16.00   PHARMACY   0   17.0		PING	1			
15.00   01500   PHARMACY		ADMINI CTRATION				
16. 00   01600   MEDICAL RECORDS & LIBRARY   -52, 931   1,032, 466   12,1916   17,00   1700   01700   SOCIAL SERVICE   0   121,1916   18,00   10800   INSERVICE EDUCATION   0   27,951   18,00   21,00   22,			1			1
17. 00   01700   SOCIAL SERVICE   0   121, 196   112, 00   18. 00   1080   INSERVICE EDUCATION   0   27, 951   18. 00   21. 00   221. 00   220.						
18. 00   01000   INSERVI CE EDUCATI ON   27. 051   27.			1			
21. 00   02100   IAS SERVI CES-SALARY & FRI NGES APPRV   0   97, 413   22. 00			1			
22.00   AZ SERVI CES-OTHER PROM COSTS APPRV   0   977, 413   22.00			1			
IMPATI ENT ROUTI NE SERVI CE COST CENTERS   30.00   300					1	
30. 00   03000   ADULTS & PEDI ATRICS   -731, 082   17, 876, 203   30. 00			0	977, 413		22.00
44. 00   04400  SKILLED NURSI NG FACILITY   0   8, 081, 104			704 000	17 07/ 000	I	4
45. 00			1			
ANCI LLARY SERVICE COST CENTERS						
54. 00   05400   RADIOLOGY-DI AGNOSTIC   0   5, 212   54. 00   60. 00   60. 00   60. 00   60. 00   60. 00   60. 00   60. 00   62. 30   60. 50   60. 00   60. 00   62. 30   60. 00   62. 30   60. 00   62. 30   60. 00   60. 00   62. 30   60. 00   60.			0	4, 811, 370		45.00
60. 00   06000   LABORATORY   0   31,601   60. 00   62. 30						4
62. 30   66250 BLOOD CLOTTI NG FOR HEMOPHILIACS   0   0   0   65. 00   06500   RESPI RATORY THERAPY   0   3, 607, 407   65. 00   66. 00   06600   PHYSI CAL THERAPY   0   5, 470, 856   66. 00   67. 00   06600   PHYSI CAL THERAPY   0   6, 329, 560   67. 00   06600   PHYSI CAL THERAPY   0   6, 329, 560   67. 00   06800   SPEECH PATHOLOGY   0   7, 209, 688   68. 00   06800   SPEECH PATHOLOGY   0   7, 209, 688   68. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   2, 715, 377   71. 00   07300   DRUGS CHARGED TO PATI ENTS   0   689, 507   73. 00   07350   MEDI CAL SERVI CES   -2, 586, 132   2, 822, 113   76. 00   03550   MEDI CAL SERVI CES   -2, 586, 132   2, 822, 113   76. 00   07697   CARDI AC REHABI LI TATI ON   -1, 084, 192   6, 358, 887   76. 01   07698   HYPERAPRI C OXYGEN THERAPY   0   0   0   0   0   0   0   0   0			1			
65. 00   06500   RESPI RATORY THERAPY   0   3, 607, 407   66. 00   67. 00   68. 00   68. 00   68. 00   68. 00   7. 209, 688   68. 00   68. 00   71. 00   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   2, 715, 377   71. 00   71. 00   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   689, 507   73. 00   76. 00			1	31, 601		
66. 00			- 1	0		
67. 00   06700   0CCUPATI ONAL THERAPY   0   6, 329, 560   68. 00   06800   SPEECH PATHOLOGY   0   7, 209, 688   68. 00   07, 20100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   2, 715, 377   71. 00   07, 200, 088   71. 00   07, 200, 088   71. 00   07, 200, 088   71. 00   07, 200, 088   71. 00   07, 200, 088   71. 00   07, 200, 088   71. 00   07, 200, 088   71. 00   07, 200, 088   71. 00   07, 200, 088   71. 00   07, 200, 088   71. 00   089, 507   71. 00   089, 507   71. 00   089, 507   71. 00   07, 60. 00			1		•	
68. 00   06800   SPEECH PATHOLOGY   0   7, 207, 688   68. 00   71. 00   7100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   2, 715, 377   71. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   689, 507   73. 00   03550   MEDI CAL SERVICES   -2, 586, 132   2, 822, 113   76. 00   76. 01   03950   PSYCHI ATRI C   -1, 084, 192   6, 358, 887   76. 01   76. 97   7697   CARDI AC REHABI LITATI ON   0   0   0   76. 98   76. 98   HYPERBARI C OXYGEN THERAPY   0   0   0   0   76. 98   76. 99   7699   LI THOTRI PSY   0   0   0   0   0   76. 99   76. 99   77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0   0   0   0   0   0   0   0   0			1			
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   2,715,377   73. 00   73. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   689,507   73. 00   73. 00   03550   MEDI CAL SERVI CES   -2,586,132   2,822,113   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 90			-1			
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 689,507 76. 00 03550 MEDI CAL SERVI CES -2,586,132 2,822,113 76. 00 76. 01 03950 PSYCHI ATRI C -1,084,192 6,358,887 76. 01 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 76. 99 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1		•	
76. 00			1			
76. 01 03950 PSYCHIATRIC					1	
76. 97					1	
76. 98   07698   HYPERBARI C OXYGEN THERAPY   0   0   0   0   76. 98   76. 99   07699   LI THOTRI PSY   0   0   0   0   0   0   0   0   0					•	
76. 99			1	ŭ,		
77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0   0   0   0    00   0UTPATI ENT SERVI CE COST CENTERS   90. 00    90. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   92. 00    93. 00   04950   SCHOOL BASED PROGRAMS   0   10, 887, 978   93. 00    93. 99   09399   PARTI AL HOSPI TALI ZATI ON PROGRAM   0   0   0    102. 00   10200   OPI OI D TREATMENT PROGRAM   0   0   0    SPECI AL PURPOSE COST CENTERS   13. 00    113. 00   11300   INTEREST EXPENSE   0   0    113. 00   SUBTOTALS (SUM OF LI NES 1 through 117)   -6, 143, 151   169, 121, 506    NONREI MBURSABLE COST CENTERS   118. 00    NONREI MBURSABLE COST CENTERS   191. 00    194. 00   07950   CHI LD CARE CENTER (MEDI CAL DAY CARE   0   0    194. 00   07950   CHI LD CARE CENTER (MEDI CAL DAY CARE   0   0    177. 00   0   0   0    10. 0   0   0   0    10. 887, 978   99. 00    113. 00   113. 00    113. 00   113. 00    114. 00   114. 00    115. 00   115. 00    116. 00   115. 00    117. 00   115. 00    118. 00   115. 00    119. 00   115. 00    119. 00   115. 00    119. 00   115. 00    119. 00   115. 00    119. 00   115. 00    119. 00   115. 00    119. 00   115. 00    119. 00   115. 00    119. 00   115. 00    119. 00   115. 00    119. 00   115. 00    119. 00   115. 00    119. 00   115. 00    119. 00   115. 00    119.			1	-	l .	
OUTPATIENT SERVICE COST CENTERS   O   O9000   CLINIC   C   CLINIC   CLINIC   C   CLINIC   C   CLINIC   C   CLINIC   CLINI			1	-	l .	
90. 00 92. 00 92. 00 92. 00 93. 00 93. 00 93. 99 074950 SCHOOL BASED PROGRAMS 90. 00 9			0	0		77.00
92. 00 93. 00 93. 00 93. 99 04950 SCHOOL BASED PROGRAMS 0 10, 887, 978 093.99 0THER REIMBURSABLE COST CENTERS 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) -6, 143, 151 169, 121, 506 NONREIMBURSABLE COST CENTERS  191. 00 19100 RESEARCH 191. 00 194. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 10, 887, 978 0 0 0 93. 99 010, 887, 978 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		RVICE COST CENTERS				4
93. 00 93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM 0 0 0 0 93. 99 0THER REI MBURSABLE COST CENTERS 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300   INTEREST EXPENSE 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) -6, 143, 151   169, 121, 506   118. 00 NONREI MBURSABLE COST CENTERS  191. 00 19100 RESEARCH 194. 00 07950   CHILD CARE CENTER (MEDICAL DAY CARE   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			-3, 304, 148	7, 238, 543		
93. 99   09399   PARTI AL HOSPI TALI ZATI ON PROGRAM   0   0   0   0						
OTHER REIMBURSABLE COST CENTERS   102.00   OPI OI D TREATMENT PROGRAM   O   O   O   SPECIAL PURPOSE COST CENTERS   O   O   O   I13.00   INTEREST EXPENSE   O   O   SUBTOTALS (SUM OF LINES 1 through 117)   -6, 143, 151   169, 121, 506   O   I18.00   NONREIMBURSABLE COST CENTERS   O   O   O   O   O   O   O   O   O					•	
102. 00   10200   OPI OI D TREATMENT PROGRAM   O   O   SPECI AL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   O   O   SUBTOTALS (SUM OF LI NES 1 through 117)   -6, 143, 151   169, 121, 506   118. 00   NONREI MBURSABLE COST CENTERS   O   2, 042, 890   194. 00   07950   CHI LD CARE CENTER (MEDI CAL DAY CARE   O   O   0   194. 00   194. 00   0   0   0   0   0   0   0   0   0			0	0		93. 99
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1			4
113.00			0	0		102. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) -6, 143, 151 169, 121, 506 118. 00 NONREI MBURSABLE COST CENTERS  191. 00 19100 RESEARCH 0 2, 042, 890 191. 00 194. 00 07950 CHI LD CARE CENTER (MEDI CAL DAY CARE 0 0 194. 00			T T			4
NONREI MBURSABLE COST CENTERS   191.00   19100   RESEARCH   0   2,042,890   191.00   194.00   07950   CHI LD CARE CENTER (MEDICAL DAY CARE   0   0   194.0			1		I .	
191. 00   19100   RESEARCH			-6, 143, 151	169, 121, 506		118. 00
194.00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 194.00			,			
				2, 042, 890		
200.00   TOTAL (SUM OF LINES 118 through 199)   -6,143,151  171,164,396   200.00			1	0		
	200.00   TOTAL (S	UM OF LINES 118 through 199)	-6, 143, 151	171, 164, 396		200.00

<u>He</u> al th	Financial Systems	CHI	LDRENS SPECIAL	IZED HOPSITAL	In Lieu of Form C	MS-2552-10
RECLAS	SIFICATIONS			Provider CCN: 31-3300		A-6
					From 01/01/2022 To 12/31/2022 Date/Time	Prepared:
					5/25/2023	5: 49 pm
	Cost Center	Increases Line #	Sal ary	Other		
	2.00	3.00	4. 00	5. 00		
	A - NURSING ADMINISTRATION					
1.00	ADMINISTRATIVE & GENERAL	5. 00	9, 479	0		1. 00
2.00	ADULTS & PEDIATRICS	30. 00	564, 902	О		2. 00
3.00	SKILLED NURSING FACILITY	44.00	363, 368	O		3. 00
4. 00	CLINIC	90.00	129, 262	<u>0</u>		4. 00
	0 B - INTEREST		1, 067, 011	0		
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	1, 567, 033		1.00
00	0			1, 567, 033		1.00
	C - TUITION REIMBURSMENT	•				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	71, 493		1. 00
2.00	NURSING ADMINISTRATION	13. 00	0	406		2. 00
3.00	PHARMACY	15. 00	0	5, 250		3. 00
4.00	ADULTS & PEDIATRICS	30.00	0	45, 753		4. 00
5. 00 6. 00	SKILLED NURSING FACILITY PHYSICAL THERAPY	44. 00 66. 00	0	12, 803 4, 200		5. 00 6. 00
7.00	OCCUPATI ONAL THERAPY	67. 00	0	5, 882		7. 00
8. 00	SPEECH PATHOLOGY	68. 00	0	3, 876		8. 00
9. 00	MEDI CAL SERVI CES	76.00	o	13, 750		9. 00
10.00	PSYCHI ATRI C	76. 01	O	17, 661		10.00
11.00	CLINIC	90.00	O	25, 059		11. 00
12.00	SCHOOL BASED PROGRAMS	93. 00	o	<u>1, 9</u> 94		12. 00
	0		0	208, 127		
	D - MME					
1. 00	CAP REL COSTS-MVBLE EQUIP		0	1, 431, 610		1. 00
	E - MALPRACTICE		0	1, 431, 610		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	3, 017		1.00
2. 00	NURSI NG ADMI NI STRATI ON	13. 00	ő	4, 596		2. 00
3. 00	PHARMACY	15. 00	Ö	11, 660		3. 00
4.00	SOCI AL SERVI CE	17.00	O	3, 164		4. 00
5.00	ADULTS & PEDIATRICS	30.00	O	98, 333		5. 00
6.00	SKILLED NURSING FACILITY	44.00	0	33, 280		6. 00
7. 00	NURSING FACILITY	45. 00	0	13, 169		7. 00
8. 00	RESPI RATORY THERAPY	65. 00	0	17, 331		8. 00
9.00	PHYSI CAL THERAPY	66.00	0	29, 551		9.00
10. 00 11. 00	OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	67. 00 68. 00	0	42, 755 36, 866		10.00
12.00	MEDI CAL SERVI CES	76. 00	0	78, 698		12. 00
13. 00	PSYCHI ATRI C	76. 01	ő	35, 346		13. 00
14. 00	CLINIC	90.00	o	15, 143		14. 00
15.00	SCHOOL BASED PROGRAMS	93.00	O	60, 537		15. 00
16.00	RESEARCH	191. 00	0	2, 283		16. 00
	0		0	485, 729		
	F - OUTPATIENT SITE DIRECTORS					
1.00	ADMINISTRATIVE & GENERAL	5. 00	278, 372	0		1.00
2.00	PHYSI CAL THERAPY	66.00	137, 198	0		2.00
3. 00 4. 00	OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	67. 00 68. 00	191, 109 193, 369	0		3. 00 4. 00
5.00	PSYCHI ATRI C	76. 01	170, 190	0		5. 00
6. 00	CLINIC	90.00	144, 103	Ö		6. 00
	0		1, 114, 341	<u> </u>		3.00
	G - THERAPY LEADS RECLASS					
1.00	SKILLED NURSING FACILITY	44.00	69, 194	0		1. 00
2.00	NURSING FACILITY	45. 00	34, 597	0		2. 00
3.00	PHYSI CAL THERAPY	66. 00	24, 646	O		3. 00
4.00	OCCUPATI ONAL THERAPY	67.00	120, 433	0		4. 00
5.00	SPEECH PATHOLOGY	68. 00	82, 032	0		5. 00
6. 00	PSYCHI ATRI C	<u>76. 01</u>	133, 460	0		6. 00
	H - MEDICAL DIRECTOR		464, 362	U		
1.00	MEDI CAL SERVI CES	76. 00	222, 089	0		1.00
2. 00	CLINIC	90.00	229, 771	Ö		2. 00
			451, 860	— — <u>ō</u>		
	I - PHARMACY STAFF RECLASS					
1.00	SKILLED NURSING FACILITY	44.00	11 <u>8, 0</u> 73	<u></u> <u>O</u>		1. 00
	0		118, 073			
	J - INCENTIVES RECLASS	1		_1		
1.00	ADMINISTRATIVE & GENERAL	5. 00	194, 089	0		1.00
2.00	OPERATION OF PLANT	7. 00 9. 00	8, 920	0		2.00
		9 (10)	4, 460	0		3.00
3.00	HOUSEKEEPI NG					1 00
3. 00 4. 00	DI ETARY	10.00	17, 880	0		4.00
3.00	1			0 0 0		4. 00 5. 00 6. 00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 CHILDRENS SPECIALIZED HOPSITAL Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/25/2023 5: 49 pm Provider CCN: 31-3300

Cost   Christop   Find respects   Cost   Christop   Cost   Chris							5/25/2023 5: 4	.9 pm
Column   C			Increases					ı
Total   Process   Tribrary   10		Cost Center	Li ne #	Sal ary	0ther			ı
Total   Process   Tribrary   10		2.00	3, 00					i
BODD   STOKEM STRYLICE	7 00							7 00
9.00   INSERVICE EDUCATION   18.00   13.380   0   10.0								
10.00   ADULTS & PEDA TRICES   30.00   148,501   0   11.00								
11.00   SKILLED MUSSING FACILITY		•						
12.00   MURSING FACILITY	10. 00	ADULTS & PEDIATRICS	30.00	148, 501	0			10. 00
13.00   RESPIRATORY THERAPY   65.00   22.320   0   13.00     14.00   PHYSICAL THERAPY   67.00   62.949   0   0   15.00     15.00   DECOMPATIONAL HIRDRY   67.00   62.949   0   0   15.00     16.00   SPEED INTERNICES   76.01   10.08   10.00     18.00   PSYCHIATRIC   76.01   10.08   10.00     19.00   CLIUNIC   79.00   0   19.00     19.00   CLIUNIC   79.00   0   19.00     19.00   CLIUNIC   79.00   0   20.00     19.00   CLIUNIC   79.00   20.00     19.00	11. 00	SKILLED NURSING FACILITY	44.00	297, 830	0			11. 00
13.00   RESPIRATORY THERAPY   65.00   22.320   0   13.00     14.00   PHYSICAL THERAPY   67.00   62.949   0   0   15.00     15.00   DECOMPATIONAL HIRDRY   67.00   62.949   0   0   15.00     16.00   SPEED INTERNICES   76.01   10.08   10.00     18.00   PSYCHIATRIC   76.01   10.08   10.00     19.00   CLIUNIC   79.00   0   19.00     19.00   CLIUNIC   79.00   0   19.00     19.00   CLIUNIC   79.00   0   20.00     19.00   CLIUNIC   79.00   20.00     19.00	12.00	NURSING FACILITY	45. 00	169, 681	0			12.00
14.00								
15.00   OCCUPATIONAL THERAPY   67.00   62.999   0   15.00		•						
16.00   SPECIN PATHOLOGY   69.00   43,033   0   17.00   17.00   17.00   18.00   18.00   19.00   18.00   19.00   18.00   19.00   18.00   19.0								
17.00   MEDICAL SERVICES   70.00   10.013   0   17.00   18.00   19.00   18.00   19.0								
18.0 0   SYCHIATRIC   76.01   120.383   0   19.00   19.00   20.00   50.00								
19.00   CLINIC   90.00   50   0   19.00   20.00   21.00   RESFARCH   191.00   21.179   0   0   21.00					0			
20.00   SCHOOL BASED PROGRAMS   93.00   375,570   0   21.00   0   0   10.00   0   21.179   0   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   20.6 (551)   2.00   0   20.0   20.0   0   20.0	18. 00	PSYCHI ATRI C	76. 01	120, 383	0			18. 00
20.00   SCHOOL BASED PROGRAMS   93.00   375,570   0   21.00   0   0   10.00   0   21.179   0   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   21.00   0   20.6 (551)   2.00   0   20.0   20.0   0   20.0	19.00	CLINIC	90.00	50	0			19.00
21.00   RESEARCH	20.00	SCHOOL BASED PROGRAMS	93.00	375, 570	0			20.00
L - LEASES   1.00   ADM INT STATI VE & GENERAL   5.00   0   607, 982   1.00   ADM INT STATI VE & GENERAL   5.00   0   206, 651   2.00   AURSI NG FACILITY   45.00   0   206, 651   2.00   AURSI NG FACILITY   45.00   0   537, 712   3.00   AURSI NG FACILITY   45.00   0   512, 792   4.00   AURSI NG FACILITY   67.00   0   512, 792   4.00   AURSI NG FACILITY   66.00   0   524, 542   5.00   AURSI NG FACILITY   7.00   AURSI NG FACILITY   44.00   292, 103   AURSI NG FACILITY   44.00   292, 103   AURSI NG FACILITY   44.00   3.245, 922   AURSI NG FACILITY   44.00   AURSI NG FACILITY   44.00   3.245, 922   AURSI NG FACILITY   44.00   3.245, 922   AURSI NG FACILITY   44.00   3.245, 922   AURSI NG FACILITY   44.00   3.258, 920   AURSI NG FACILITY   44.00   AURSI NG FACILITY   44.00   3.258, 920   AURSI NG FACILITY   44.00   AURSI NG FACILITY   44.0		•						
L - LEASES   1.00   ADM INT STATI VE & GENERAL   5.00   0   607, 982   1.00   ADM INT STATI VE & GENERAL   5.00   0   206, 651   2.00   AURSI NG FACILITY   45.00   0   206, 651   2.00   AURSI NG FACILITY   45.00   0   537, 712   3.00   AURSI NG FACILITY   45.00   0   512, 792   4.00   AURSI NG FACILITY   67.00   0   512, 792   4.00   AURSI NG FACILITY   66.00   0   524, 542   5.00   AURSI NG FACILITY   7.00   AURSI NG FACILITY   44.00   292, 103   AURSI NG FACILITY   44.00   292, 103   AURSI NG FACILITY   44.00   3.245, 922   AURSI NG FACILITY   44.00   AURSI NG FACILITY   44.00   3.245, 922   AURSI NG FACILITY   44.00   3.245, 922   AURSI NG FACILITY   44.00   3.245, 922   AURSI NG FACILITY   44.00   3.258, 920   AURSI NG FACILITY   44.00   AURSI NG FACILITY   44.00   3.258, 920   AURSI NG FACILITY   44.00   AURSI NG FACILITY   44.0	21.00	0	— 1 <u>71.</u> 00					Z 1. 00
1.00   ADMINISTRATIVE & GENERAL   5.00   0   607, 982   1.00   3.00   3.00   9HYSI CAL THERAPY   66.00   0   537, 712   3.30   3.00   4.00   ADMINISTRATIVE & COLOR   5.00   5.00   5.24, 5.42   5.00   5.0		U LEACEC		1,070,037	U			I
2.00   MURSING FACILITY	4 00				, n = n = -1			4
3.00   PHYSICAL THERAPY								
4. 00   OCCUPATI ONAL THERAPY		•						
5.00   SPECCH PATHOLOGY	3.00	PHYSI CAL THERAPY	66.00	O	537, 712			3. 00
5.00   SPECCH PATHOLOGY	4.00	OCCUPATI ONAL THERAPY	67.00	ol	512, 792			4. 00
Color   PSYCHIATRIC   Color	5 00			0				5 00
7. 00		•		0				
SCHOOL BASED PROGRAMS   93.00   0   316.586   0   0   0   3.506,586   0   0   0   3.506,586   0   0   0   3.506,586   0   0   0   0   0   0   0   0   0				0				
N - PHYSICI AN RECLASS   1.00   20,00				0				
No.   PHYSICIAN RECLASS	8.00	SCHOOL BASED PROGRAMS	93.00					8. 00 I
1. 00		0		U	3, 506, 586			I
2.00   SKILLED NURSING FACILITY								1
3.00   PSYCHIATRIC   76.01   725, 850   251,000   0   4.00   0   0   0   4.00   0   0   0   4.00   0   0   0   4.00   0   0   0   0   0   0   0   0   0								
A 00   CLINIC   90.00   3,248,922   0   0   0   0   0   0   0   0   0	2.00	SKILLED NURSING FACILITY	44.00	292, 103	0			2. 00
N - THERAPY SCHEDULING	3.00	PSYCHI ATRI C	76. 01	725, 850	251, 000			3. 00
N - THERAPY SCHEDULING	4.00	CLINIC	90.00	3, 248, 922	0			4.00
1.00   PHYSICAL THERAPY		0		4, 913, 954	251, 000			ı
2. 00   OCCUPATIONAL THERAPY   67, 00   335, 388   0   3.00   SPECH PATHOLOGY   68, 00   325, 870   0   0   3.00		N - THERAPY SCHEDULING						ı
3. 00 SPEECH PATHOLOGY 68. 00 325, 870 0 4. 00 4. 00 MEDI CAL SERVI CES 76. 00 248, 972 0 5. 00  CLINIC 90. 0 363, 336 0 70  0 - INSERVI CE EDUCATI ON	1.00	PHYSI CAL THERAPY	66.00	237, 189	0			1. 00
3. 00 SPEECH PATHOLOGY 68. 00 325, 870 0 4. 00 4. 00 MEDI CAL SERVI CES 76. 00 248, 972 0 5. 00  CLINIC 90. 0 363, 336 0 70  0 - INSERVI CE EDUCATI ON	2.00	OCCUPATIONAL THERAPY	67.00	335, 388	0			2.00
4.00   MEDICAL SERVICES   76.00   248, 972   0   5.00   0   0   0   0   0   0   0   0   0		SPEECH PATHOLOGY						
S. 00   CLINIC   90.00   363,336   0   0   0   1,510,755   0   0   1,510,755   0   0   0   1,510,755   0   0   0   1,510,755   0   0   0   1,500   0   1,693   0   0   0   0   0,693   0   0   0   0,796   0   0   0,000   0   0,000   0   0,000   0								
0 - INSERVICE EDUCATION		•						
0 - INSERVICE EDUCATION	0.00	0	— <del>/0.00</del>		— — <u>ö</u>			J. 55
1.00   ADMIN ISTRATI VE & GENERAL   5.00   0   7,996   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   3.00   4.00   4.00   0   1.693   2.20   3.00   4.00   0   1.693   4.00   3.00   4.00   0   1.693   4.00   3.00   4.00   0   5.00   4.00   5.00   4.00   5.00   6.0		O - INSERVICE EDUCATION	1	.,				I
2. 00 OPERATION OF PLANT 7. 00 0 1,693 3. 00 HOUSEKEEPING 9. 00 0 1,224 4. 00 DI ETARY 10. 00 0 758 5. 00 NURSING ADMINISTRATION 13. 00 0 260 6. 00 PHARMACY 15. 00 0 541 8. 00 SOCIAL SERVICE 17. 00 0 268 9. 00 ADULTS & PEDIATRICS 30. 00 0 6,189 10. 00 SKILLED NURSING FACILITY 44. 00 0 1,810 13. 00 CCUPATIONAL THERAPY 67. 00 0 1,810 15. 00 MEDICAL SERVICES 76. 00 0 1,986 16. 00 PHYSICAL THERAPY 67. 00 0 1,810 16. 00 PSYCHIATRIC 76. 01 0 2,477 17. 00 18. 00 SCHOL SERVICES 76. 00 0 2,477 17. 00 TI. 00 18. 00 SCHOL SERVICES 76. 00 0 2,477 17. 00 MEDICAL SERVICE 76. 01 0 2,477 17. 00 CLINIC 90. 00 0 4,785 0 ADULTS & PEDIATRICS 30. 00 0 447,721 0 ADULTS & PEDIATRICS 30. 00 0 447,721 0 NURSING FACILITY 44. 00 3,4783 0 NURSI	1 00		5 00	0	7 996			1 00
3. 00 HOUSEKEEPING 9. 00 0 1, 224 3. 00 4. 00 DI ETARY 10. 00 0 758 4. 00 5. 00 NURSI NG ADMINI STRATI ON 13. 00 0 260 5. 00 6. 00 PHARMACY 15. 00 0 650 6. 00 7. 00 MEDI CAL RECORDS & LI BRARY 16. 00 0 541 7. 00 8. 00 SOCI AL SERVI CE 17. 00 0 268 8. 00 9. 00 ADULTS & PEDI ATRI CS 30. 00 0 6. 189 9. 00 10. 00 SKI LLED NURSI NG FACI LI TY 44. 00 0 4. 974 10. 00 11. 00 RESPIRATORY THERAPY 65. 00 0 373 11. 00 12. 00 PHYSI CAL THERAPY 66. 00 0 1, 806 12. 00 13. 00 OCCUPATI ONAL THERAPY 67. 00 0 1, 915 13. 00 14. 00 SPEECH PATHOLOGY 68. 00 0 1, 810 14. 00 15. 00 MEDI CAL SERVI CE 76. 00 0 1, 986 15. 00 16. 00 PSYCHI ATRI C 76. 01 0 2, 477 16. 00 17. 00 CLI NI C 76. 01 0 2, 477 16. 00 18. 00 SCHOOL BASED PROGRAMS 93. 00 0 47.885 0 18. 00  P - SOCI AL SERVI CE				· · · · · · · · · · · · · · · · · · ·				
4.00   DIETARY   10.00   0   758   4.00   5.00   NURSI NG ADMINI STRATI ON   13.00   0   260   6.00   6.00   7.00   MEDI CAL RECORDS & LI BRARY   16.00   0   541   7.00   8.00   SOCI AL SERVI CE   17.00   0   268   8.00   9.00   ADULTS & PEDI ATRI CS   30.00   0   4.974   10.00   11.00   12.00   19.30   12.00   19.30   12.00   19.30   12.00   19.30   12.00   19.30   12.00   19.30   13.00   15.				· · · · · · · · · · · · · · · · · · ·				
S. 00   NURSI NG ADMI NI STRATI ON   13. 00   0   260   6. 0				-				
6. 00 PHARMACY 15. 00 0 650 6. 00 7. 00 MEDI CAL RECORDS & LI BRARY 16. 00 0 541 7. 00 8. 00 SOCI AL SERVI CE 17. 00 0 268 8. 00 10. 00 SKI LLED NURSI NG FACI LI TY 44. 00 0 4, 974 10. 00 11. 00 RESPI RATORY THERAPY 65. 00 0 373 111. 00 12. 00 PHYSI CAL THERAPY 66. 00 0 1, 806 12. 00 13. 00 OCCUPATI ONAL THERAPY 67. 00 0 1, 915 13. 00 14. 00 SPEECH PATHOLOGY 68. 00 0 1, 810 14. 00 15. 00 MEDI CAL SERVI CES 76. 00 0 1, 986 15. 00 16. 00 PSYCHI ATRI C 76. 01 0 2, 477 16. 00 17. 00 CLI NI C 90. 00 0 1, 705 18. 00 SCHOOL BASED PROGRAMS 93. 00 0 4, 785 0 18. 00 10. 00 SCHOOL BASED PROGRAMS 93. 00 0 4, 785 0 18. 00 10. 00 SCHOOL BASED PROGRAMS 93. 00 0 4, 785 0 18. 00 10. 00 SCHOOL BASED ROGRAMS 93. 00 0 4, 785 0 18. 00 10. 00 SCHOOL BASED ROGRAMS 93. 00 0 0 4, 785 0 18. 00 10. 00 SCHOOL BASED ROGRAMS 93. 00 0 0 4, 785 0 18. 00 10. 00 SCHOOL BASED ROGRAMS 93. 00 0 0 4, 785 0 18. 00 10. 00 SCHOOL BASED ROGRAMS 93. 00 0 0 4, 785 0 18. 00 10. 00 SCHOOL BASED ROGRAMS 93. 00 0 0 4, 785 0 18. 00 10. 00 SCHOOL BASED ROGRAMS 93. 00 0 0 4, 785 0 18. 00 10. 00 SCHOOL BASED ROGRAMS 93. 00 0 0 4, 785 0 18. 00 10. 00 SCHOOL BASED ROGRAMS 93. 00 0 0 4, 785 0 93. 00 0 0 4, 785 0 93. 00 0 0 4, 785 0 93. 00 0 0 4, 785 0 93. 00 0 0 4, 785 0 93. 00 0 0 4, 785 0 93. 00 0 94. 00 93. 00 94. 00 93. 00 94. 00 93. 00 94. 00 93. 00 94. 00 93. 00 94.		•						
7. 00 MEDI CAL RECORDS & LI BRARY 16. 00 0 541 7. 00 8. 00 SOCI AL SERVI CE 17. 00 0 268 8. 00 9. 00 ADULTS & PEDI ATRI CS 30. 00 0 6, 189 9. 00 10. 00 SKI LLED NURSI NG FACI LI TY 44. 00 0 4, 974 10. 00 11. 00 RESPI RATORY THERAPY 65. 00 0 373 11. 00 12. 00 PHYSI CAL THERAPY 66. 00 0 1, 806 112. 00 13. 00 OCCUPATI ONAL THERAPY 67. 00 0 1, 915 13. 00 14. 00 SPEECH PATHOLOGY 68. 00 0 1, 915 13. 00 15. 00 MEDI CAL SERVI CES 76. 00 0 1, 986 15. 00 16. 00 PSYCHI ATRI C 76. 01 0 2, 477 16. 00 17. 00 CLI NI C 90. 00 0 2, 200 17. 00 18. 00 SCHOOL BASED PROGRAMS 93. 00 0 41, 905  P - SOCI AL SERVI CE  1. 00 ADULTS & PEDI ATRI CS 30. 00 495, 921 0 1. 00 2. 00 SKI LLED NURSI NG FACI LI TY 44. 00 34, 783 0 2. 00 3. 00 NURSI NG FACI LI TY 44. 00 34, 783 0 3. 00 0 NURSI NG FACI LI TY 45. 00 44, 721 0 0 3. 00 0 NURSI NG FACI LI TY 45. 00 44, 721 0 0 3. 00		•		O				
8.00 SOCI AL SERVI CE 17.00 0 268 8.00 9.00 ADULTS & PEDI ATRI CS 30.00 0 6, 189 9.00 10.00 SKI LLED NURSI NG FACI LI TY 44.00 0 4, 974 10.00 11.00 RESPI RATORY THERAPY 65.00 0 373 111.00 12.00 PHYSI CAL THERAPY 66.00 0 1, 806 12.00 13.00 OCCUPATI ONAL THERAPY 67.00 0 1, 915 13.00 14.00 SPEECH PATHOLOGY 68.00 0 1, 810 14.00 15.00 MEDI CAL SERVI CES 76.00 0 1, 986 15.00 16.00 PSYCHI ATRI C 76.01 0 2, 477 16.00 17.00 CLI NI C 90.00 0 2, 200 17.00 18.00 SCHOOL BASED PROGRAMS 93.00 0 4, 785 0 18.00 D SCHOOL BASED PROGRAMS 93.00 0 41, 905 D AULTS & PEDI ATRI CS 30.00 495, 921 0 1.00 2.00 SKI LLED NURSI NG FACI LI TY 44.00 34, 783 0 2.00 3.00 NURSI NG FACI LI TY 45.00 44, 721 0 0 33.00 NURSI NG FACI LI TY 45.00 44, 721 0 0 33.00				0				
9. 00 ADULTS & PEDI ATRI CS 30. 00 0 6, 189 9. 00 10. 00 SKI LLED NURSI NG FACI LI TY 44. 00 0 44, 974 10. 00 11. 00 RESPI RATORY THERAPY 65. 00 0 373 11. 00 12. 00 PHYSI CAL THERAPY 66. 00 0 1, 806 12. 00 13. 00 0CCUPATI ONAL THERAPY 67. 00 0 1, 915 13. 00 14. 00 SPEECH PATHOLOGY 68. 00 0 1, 810 14. 00 15. 00 MEDI CAL SERVI CES 76. 00 0 1, 886 15. 00 16. 00 PSYCHI ATRI C 76. 01 0 2, 477 16. 00 17. 00 CLI NI C 90. 00 0 41, 785 0 18. 00  SCHOOL BASED PROGRAMS 93. 00 0 47, 785 0 18. 00  P - SOCI AL SERVI CE  1. 00 ADULTS & PEDI ATRI CS 30. 00 495, 921 0 1. 00 2. 00 NURSI NG FACI LI TY 44. 00 34, 783 0 2. 00 3. 00 NURSI NG FACI LI TY 45. 00 44, 721 0 3. 00  NURSI NG FACI LI TY 45. 00 44, 721 0 3. 00  10. 00 575, 425 0 0	7. 00	MEDICAL RECORDS & LIBRARY	16. 00	0	541			7. 00
9. 00 ADULTS & PEDI ATRI CS 30. 00 0 6, 189 9. 00 10. 00 SKI LLED NURSI NG FACI LI TY 44. 00 0 44, 974 10. 00 11. 00 RESPI RATORY THERAPY 65. 00 0 373 11. 00 12. 00 PHYSI CAL THERAPY 66. 00 0 1, 806 12. 00 13. 00 0CCUPATI ONAL THERAPY 67. 00 0 1, 915 13. 00 14. 00 SPEECH PATHOLOGY 68. 00 0 1, 810 14. 00 15. 00 MEDI CAL SERVI CES 76. 00 0 1, 886 15. 00 16. 00 PSYCHI ATRI C 76. 01 0 2, 477 16. 00 17. 00 CLI NI C 90. 00 0 41, 785 0 18. 00  SCHOOL BASED PROGRAMS 93. 00 0 47, 785 0 18. 00  P - SOCI AL SERVI CE  1. 00 ADULTS & PEDI ATRI CS 30. 00 495, 921 0 1. 00 2. 00 NURSI NG FACI LI TY 44. 00 34, 783 0 2. 00 3. 00 NURSI NG FACI LI TY 45. 00 44, 721 0 3. 00  NURSI NG FACI LI TY 45. 00 44, 721 0 3. 00  10. 00 575, 425 0 0	8.00	SOCI AL SERVI CE	17. 00	0	268			8. 00
10. 00				ol				1
11. 00       RESPIRATORY THERAPY       65. 00       0       373       11. 00         12. 00       PHYSI CAL THERAPY       66. 00       0       1, 806       12. 00         13. 00       OCCUPATI ONAL THERAPY       67. 00       0       1, 915       13. 00         14. 00       SPEECH PATHOLOGY       68. 00       0       1, 810       14. 00         15. 00       MEDI CAL SERVI CES       76. 00       0       1, 986       15. 00         16. 00       PSYCHI ATRI C       76. 01       0       2, 477       16. 00         17. 00       CLI NI C       90. 00       0       2, 200       17. 00         18. 00       SCHOOL BASED PROGRAMS       93. 00       0       4, 785       18. 00         P - SOCI AL SERVI CE       30. 00       495, 921       0       1. 00         2. 00       SKI LLED NURSI NG FACI LI TY       44. 00       34, 783       0       2. 00         3. 00       NURSI NG FACI LI TY       45. 00       44, 721       0       0       3. 00				-				
12. 00 PHYSI CAL THERAPY 66. 00 0 1,806 12. 00 13. 00 OCCUPATI ONAL THERAPY 67. 00 0 1,915 13. 00 14. 00 SPEECH PATHOLOGY 68. 00 0 1,810 14. 00 15. 00 MEDI CAL SERVI CES 76. 00 0 1,986 15. 00 16. 00 PSYCHI ATRI C 76. 01 0 2,477 16. 00 17. 00 CLI NI C 90. 00 0 2,477 16. 00 18. 00 SCHOOL BASED PROGRAMS 93. 00 0 4,785 0 18. 00 P - SOCI AL SERVI CE  1. 00 ADULTS & PEDI ATRI CS 30. 00 495, 921 0 1. 00 2. 00 SKI LLED NURSI NG FACI LI TY 44. 00 34, 783 0 2. 00 3. 00 NURSI NG FACI LI TY 45. 00 44, 721 0 0 3. 00 0 T575, 425 0 0								
13. 00 OCCUPATI ONAL THERAPY 67. 00 0 1, 915 14. 00 SPEECH PATHOLOGY 68. 00 0 1, 810 15. 00 MEDI CAL SERVI CES 76. 00 0 1, 986 16. 00 PSYCHI ATRI C 76. 01 0 2, 477 17. 00 CLI NI C 90. 00 0 2, 200 18. 00 SCHOOL BASED PROGRAMS 93. 00 0 4, 785 0 P - SOCI AL SERVI CE  1. 00 ADULTS & PEDI ATRI CS 30. 00 495, 921 0 2. 00 SKI LLED NURSI NG FACI LI TY 44. 00 34, 783 0 3. 00 NURSI NG FACI LI TY 45. 00 44, 721 0 0 575, 425 0 0 575, 425 0								
14. 00   SPEECH PATHOLOGY   68. 00   0   1,810   14. 00   15. 00   MEDI CAL SERVI CES   76. 00   0   1,986   15. 00   16. 00   PSYCHI ATRI C   76. 01   0   2,477   16. 00   17. 00   CLI NI C   90. 00   0   2,200   17. 00   18. 00   SCHOOL BASED PROGRAMS   93. 00   0   4,785   18. 00								
15. 00 MEDI CAL SERVI CES 76. 00 0 1, 986 15. 00 16. 00 PSYCHI ATRI C 76. 01 0 2, 477 16. 00 17. 00 CLI NI C 90. 00 0 2, 200 17. 00 18. 00 SCHOOL BASED PROGRAMS 93. 00 0 4, 785 0 18. 00 P - SOCI AL SERVI CE  1. 00 ADULTS & PEDI ATRI CS 30. 00 495, 921 0 1. 00 2. 00 SKI LLED NURSI NG FACI LI TY 44. 00 34, 783 0 2. 00 3. 00 NURSI NG FACI LI TY 45. 00 44, 721 0 3. 00 0 575, 425 0 0				U				
16. 00 PSYCHIATRIC 76. 01 0 2, 477 17. 00 CLINIC 90. 00 0 2, 200 17. 00 18. 00 SCHOOL BASED PROGRAMS 93. 00 0 4, 785 0 0 0 41, 905  P - SOCIAL SERVICE  1. 00 ADULTS & PEDIATRICS 30. 00 495, 921 0 2. 00 SKILLED NURSING FACILITY 44. 00 34, 783 0 3. 00 NURSING FACILITY 45. 00 44, 721 0 0 575, 425 0		•		O				
17. 00   CLINI C   90. 00   0   2, 200   17. 00   18. 00     SCHOOL BASED PROGRAMS   93. 00   0   4, 785   0   18. 00	15. 00	MEDI CAL SERVI CES		0	1, 986			
18. 00 SCHOOL BASED PROGRAMS 93. 00 0 4, 785 0 41, 905 P - SOCI AL SERVI CE  1. 00 ADULTS & PEDI ATRI CS 30. 00 495, 921 0 1. 00 2. 00 SKI LLED NURSI NG FACI LI TY 44. 00 34, 783 0 2. 00 3. 00 NURSI NG FACI LI TY 45. 00 44, 721 0 3. 00 0 575, 425 0	16.00	PSYCHI ATRI C	76. 01	0	2, 477			16. 00
18. 00 SCHOOL BASED PROGRAMS 93. 00 0 4, 785 0 41, 905 P - SOCI AL SERVI CE  1. 00 ADULTS & PEDI ATRI CS 30. 00 495, 921 0 1. 00 2. 00 SKI LLED NURSI NG FACI LI TY 44. 00 34, 783 0 2. 00 3. 00 NURSI NG FACI LI TY 45. 00 44, 721 0 3. 00 0 575, 425 0	17.00	CLINIC	90.00	o	2, 200			17. 00
0 0 41,905 P - SOCIAL SERVICE 1. 00 ADULTS & PEDIATRICS 30.00 495,921 0 1.00 2. 00 SKILLED NURSING FACILITY 44.00 34,783 0 2.00 3. 00 NURSING FACILITY 45.00 44,721 0 3.00 0 575,425 0		SCHOOL BASED PROGRAMS	93.00	o				18. 00
P - SOCIAL SERVICE  1. 00 ADULTS & PEDIATRICS 30. 00 495, 921 0 2. 00 SKILLED NURSING FACILITY 44. 00 34, 783 0 3. 00 NURSING FACILITY 45. 00 44. 721 0 0 575, 425 0		0						1
1.00 ADULTS & PEDIATRICS 30.00 495, 921 0 2.00 SKILLED NURSING FACILITY 44.00 34, 783 0 3.00 NURSING FACILITY 45.00 44, 721 0 0 575, 425 0		P - SOCIAL SERVICE	<u> </u>		, . 50			
2. 00 SKILLED NURSING FACILITY 44. 00 34, 783 0 2. 00 3. 00 NURSING FACILITY 45. 00 44, 721 0 0 3. 00	1.00		30 00	495 921	n			1.00
3. 00 NURSING FACILITY 45. 0044, 721 0 0 575, 425 0 0								
0 575, 425 0		•						
	5.00	noncino i Aci Li II	- 45.00					J. 00
300. 00 pirana rotar. Thereases     11, 074, 010  7, 471, 770	500 00	Grand Total: Increases						500 00
	500.00	pi and Total. THEFEASES	ı I	11,074,018	1, 471, 770		l	300.00

Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/25/2023 5: 49 pm

						5/25/2	2023 5:49 pm
		Decreases	0.1				
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther W 9.00	10.00		
	A - NURSING ADMINISTRATION	7.00	8.00	9.00	10.00		
1.00	NURSI NG ADMI NI STRATI ON	13. 00	1, 067, 011	0	0		1.00
2.00		0.00	0	0	0		2. 00
3.00		0.00	O	0	0		3. 00
4.00		000	0	0	0		4. 00
	0		1, 067, 011				
	B - INTEREST	440.00	ما	4 5/3 000			
1. 00	I NTEREST EXPENSE	1 <u>13.</u> 00		1, 567, 033 1, 567, 033	11		1.00
	C - TUITION REIMBURSMENT		U	1, 567, 033			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	208, 127	0		1.00
2. 00	EMILEGIEE BENEFITIS BETTIKTMENT	0.00	o	0	o		2. 00
3. 00		0.00	o	Ö	o		3. 00
4.00		0.00	o	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 10. 00		0. 00 0. 00	0	0	0		9. 00 10. 00
11. 00		0.00	0	0	0		11.00
12. 00		0.00	o	Ö	o		12. 00
				208, 127			
	D - MME						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	<u>1, 431, 6</u> 10	9		1. 00
	0		0	1, 431, 610			
	E - MALPRACTI CE			405 700	ما		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	485, 729	0		1.00
2. 00 3. 00		0. 00 0. 00	0	0	0		2. 00 3. 00
4.00		0.00	o	0	0		4. 00
5.00		0.00	o	o	0		5. 00
6. 00		0.00	o	Ö	o		6. 00
7.00		0.00	O	0	0		7. 00
8.00		0.00	O	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 13. 00		0. 00 0. 00	0	0	0		12. 00 13. 00
14. 00		0.00	0	0	0		14. 00
15. 00		0.00	0	Ö	0		15. 00
16. 00		0.00	Ö	0	0		16. 00
		+		485, 729	— —  —		10.00
	F - OUTPATIENT SITE DIRECTORS		<u>'</u>				
1.00	ADMINISTRATIVE & GENERAL	5. 00	1, 114, 341	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. 00	0	0	0		5.00
6. 00		<u> </u>	1, 114, 341	0	— — — Ч		6. 00
	G - THERAPY LEADS RECLASS		1, 114, 341	<u> </u>			
1. 00	I NSERVI CE EDUCATI ON	18. 00	464, 362	0	0		1. 00
2.00		0.00	0	Ō	o		2. 00
3.00		0.00	o	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
	0 LL MEDICAL DIRECTOR		464, 362	Ō			
1 00	H - MEDICAL DIRECTOR ADMINISTRATIVE & GENERAL	5.00	4E1 040	0	0		1 00
1. 00 2. 00	ADMINISTRATIVE & GENERAL	0.00	451, 860 0	0	0		1. 00 2. 00
2.00			451, 860				2.00
	I - PHARMACY STAFF RECLASS		10.7000	<u> </u>			
1.00	PHARMACY	15. 00	118, 073	0	0		1.00
			118, 073	0			
	J - INCENTIVES RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	1, 678, 837	0	0		1. 00
2.00		0.00	O	0	0		2. 00
3.00		0.00	0	0	0		3. 00
4.00		0. 00 0. 00	O	0	0		4.00
		a and	Ol	0	0		5. 00
5. 00 6. 00		0.00	o	Ö	Ö		6. 00

Health Financial Systems RECLASSIFICATIONS CHILDRENS SPECIALIZED HOPSITAL
Provider CCN: 31-3300

Peri od: From 01/01/2022 To 12/31/2022

Date/Time Prepared: 5/25/2023 5:49 pm

						5/25/2023 5:	49 pili
		Decreases					
	Cost Center	Li ne #	Sal ary		t. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 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	О		9. 00
10.00		0.00	ol	0	ol		10.00
11. 00		0.00	o	0	o		11. 00
12. 00		0.00	ol	Ö	o		12. 00
13. 00		0.00	ő	0	Ö		13. 00
				0			
14. 00		0.00	0	0	0		14.00
15. 00		0.00	0	0	0		15. 00
16.00		0.00	0	0	0		16. 00
17.00		0.00	0	0	0		17. 00
18.00		0.00	0	0	О		18. 00
19. 00		0.00	0	0	О		19. 00
20.00		0.00	ol	0	o		20.00
21. 00		0.00	ol	0	o		21. 00
21.00			1, 678, 837	- — — <del>ŏ</del>	· — — ്		21.00
	L - LEASES		1, 070, 037	U U			-
4 00		4 00		0.507.507	10		4 00
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	3, 506, 586	10		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	О		5. 00
6.00		0.00	ol	0	ol		6. 00
7. 00		0.00	o	0	o		7. 00
8. 00		0.00	o	0	o		8. 00
0.00			<del> </del>	3, 506, 586	· — — Ч		0.00
	M - PHYSICIAN RECLASS			3, 300, 300			-
4 00		77,00	4 040 054	254 200			4 00
1.00	MEDICAL SERVICES	76. 00	4, 913, 954	251, 000	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	О		4. 00
	0 = = = = = =		4, 913, 954	251, 000			1
	N - THERAPY SCHEDULING	•	*		•		1
1.00	ADMINISTRATIVE & GENERAL	5. 00	1, 510, 755	0	0		1.00
2.00	TIOMIN WI STRATT VE & GENERALE	0.00	0	Ö	o		2. 00
3.00		0.00	o	0	0		3.00
			O O	0	- 1		
4.00		0.00	U	U	0		4. 00
5.00	<u> </u>	0.00		0	0		5. 00
	0		1, 510, 755	0			_
	O - INSERVICE EDUCATION						
1.00	INSERVICE EDUCATION	18. 00	0	41, 905	0		1. 00
2.00		0.00	O	0	О		2. 00
3.00		0.00	o	0	ol		3. 00
4.00		0.00	o	0	o		4. 00
5. 00		0.00	ő	0	o		5. 00
6. 00	•	0.00		0	0		6. 00
			O O	0	- 1		
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	О		11. 00
12.00		0.00	ol	0	ol		12. 00
13. 00		0.00	ol	0	o		13. 00
14. 00		0.00	Ŏ	0	o		14. 00
15. 00		0.00		0	Ö		15. 00
			O O	0			
16.00		0.00	0	O O	0		16.00
17. 00	1	0.00	0	0	0		17. 00
18. 00	L — — — — — —	0.00	0	0	0		18. 00
	0		0	41, 905			_
	P - SOCIAL SERVICE						
1.00	SOCI AL SERVI CE	17. 00	575, 425	0	0		1. 00
2.00		0.00	070, 120	Ö	o		2. 00
3. 00		0.00		0			3. 00
5.00		— — <del>"</del>	575, 425	- — — <del>}</del>	· — — 尚		3.00
E00 00	Crand Tatal: Dagrages			7 401 000			E00 00
500.00	Grand Total: Decreases		11, 894, 618	7, 491, 990			500.00

6.00

7.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 31-3300 Peri od: Worksheet A-7 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/25/2023 5:49 pm Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 156, 400 919, 400 919, 400 0 1.00 0 2.00 Land Improvements 3, 312, 121 173, 642 173, 642 0 2.00 0 3.00 93, 959, 677 16, 707, 166 16, 707, 166 3.00 Buildings and Fixtures 0 0 4.00 Building Improvements 15, 856, 062 421, 190 421, 190 0 4.00 5.00 Fixed Equipment 36, 990, 857 1,035,103 1, 035, 103 0 5.00 0 6.00 Movable Equipment 63, 693, 274 2, 205, 799 2, 205, 799 0 6.00 0 7.00 HIT designated Assets 7.00 0 0 8.00 Subtotal (sum of lines 1-7) 213, 968, 391 21, 462, 300 21, 462, 300 0 8.00 9.00 Reconciling Items 0 0 9.00 2<u>13, </u>968, 391 Total (line 8 minus line 9) O 10.00 10.00 21, 462, 300 21, 462, 300 0 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1,075,800 0 1.00 2.00 Land Improvements 3, 485, 763 0 2.00 3.00 Buildings and Fixtures 110, 666, 843 0 3.00 0 4.00 Building Improvements 16, 277, 252 4.00 5.00 Fi xed Equipment 38, 025, 960 0 5.00

65, 899, 073

235, 430, 691

235, 430, 691

0

0

0

0

Movable Equipment

Reconciling Items

HIT designated Assets

10.00 Total (line 8 minus line 9)

Subtotal (sum of lines 1-7)

6.00

7.00

8.00

9.00

Health Financial Systems C	HILDRENS SPECIA	LIZED HOPSITAL	_	In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 31-3300	Peri od:	Worksheet A-7		
				From 01/01/2022 To 12/31/2022	Part II Date/Time Pre	narodi	
				10 12/31/2022	5/25/2023 5: 4	pareu. 9 pm	
		SI	UMMARY OF CAF	PITAL			
Cost Center Description	Depreciation	Lease	Interest	Insurance (see			
					instructions)		
DART LL DESCRIPTION OF MICHIES FROM WOR	9.00	10.00	11.00	12.00	13. 00		
PART II - RECONCILIATION OF AMOUNTS FROM WOR	· · · · · · · · · · · · · · · · · · ·	•	and 2				
1.00 CAP REL COSTS-BLDG & FLXT	8, 556, 185			0	01	1.00	
2. 00 CAP REL COSTS-MVBLE EQUIP	0 55, 405			0	01	2.00	
3.00 Total (sum of lines 1-2)	8, 556, 185		)	0 0	0	3. 00	
	SUMMARY 0	F CAPITAL					
Cost Center Description	Other	Total (1) (sum					
cost center bescription	Capi tal -Rel ate	. , ,	'				
	d Costs (see	through 14)					
	instructions)	in odgii ii)					
	14. 00	15. 00	1				
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	and 2				
1.00 CAP REL COSTS-BLDG & FLXT	0	8, 556, 185	5			1.00	
2.00 CAP REL COSTS-MVBLE EQUIP	0	C			ļ	2. 00	
3.00 Total (sum of lines 1-2)	0	8, 556, 185	5		ļ	3.00	

Heal th	n Financial Systems CF	HILDRENS SPECIA	LIZED HOPSITAL		In Lieu of Form CMS-255		
RECON	CILIATION OF CAPITAL COSTS CENTERS				Peri od: Worksheet A-7 From 01/01/2022 Part III To 12/31/2022 Date/Time Pre 5/25/2023 5:4		pared:
		COMPUTATION OF RATIOS			ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description		Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col.	Ratio (see instructions)	Insurance	
				2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		_	1 4/0 504 /45			
1.00	CAP REL COSTS-BLDG & FIXT	169, 531, 617	0	169, 531, 617		0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	65, 899, 073	l .	65, 899, 073			2.00
3.00	Total (sum of lines 1-2)	235, 430, 690		235, 430, 690			3. 00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL							
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate	col s. 5			
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0	(	7, 124, 575		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	(	1, 431, 610		2. 00
3.00	Total (sum of lines 1-2)	0	0	(	8, 556, 185	-3, 506, 586	3. 00
			Sl	JMMARY OF CAPI	ΓAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
					Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)	3 ,	
		11.00	12.00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	1, 567, 033	0	(	0	5, 185, 022	1. 00
2 00	CAD DEL COSTS MADLE FOLLID	1	۱ ۸	1	0	1 /21 610	2 00

0 1, 567, 033

0 0 0

5, 185, 022 1. 00 1, 431, 610 2. 00 6, 616, 632 3. 00

2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Provider CCN: 31-3300 

					To 12/31/2022	Date/Time Prep 5/25/2023 5:49	
				Expense Classification or	Worksheet A	372372023 3.4	y piii
				To/From Which the Amount is			
	Cost Center Description		Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1 00	I	1.00	2.00	3.00	4. 00	5. 00	4 00
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2. 00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
	COSTS-MVBLE EQUIP (chapter 2)						
3.00	Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time	В	_0 275	ADMINISTRATIVE & GENERAL	5. 00	0	4. 00
4.00	di scounts (chapter 8)		-7, 273	ADMINISTRATIVE & GENERAL	3.00		4.00
5.00	Refunds and rebates of		0		0.00	0	5.00
, 00	expenses (chapter 8)				0.00		
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7. 00	Tel ephone servi ces (pay		0		0.00	0	7. 00
	stations excluded) (chapter						
0.00	[21]		0		0.00		0.00
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	Provi der-based physician	A-8-2	-4, 943, 910			0	10.00
44.00	adjustment				0.00		44.00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization	A-8-1	3, 057, 630			0	12. 00
	transactions (chapter 10)		.,,				
13. 00	Laundry and linen service		0		0.00		
14.00	Cafeteria-employees and guests		-134, 185		10.00	1	14. 00
15. 00	Rental of quarters to employee and others	В	-300, 537	OPERATION OF PLANT	7. 00	0	15. 00
16.00	Sale of medical and surgical		0		0.00	o	16.00
	supplies to other than						
17 00	patients		0		0.00	0	17 00
17. 00	Sale of drugs to other than patients		U		0.00	U	17. 00
18. 00	Sale of medical records and	В	-52, 931	MEDICAL RECORDS & LIBRARY	16.00	О	18. 00
	abstracts						
19. 00	Nursing and allied health education (tuition, fees,	В	0		0.00	0	19. 00
	books, etc.)						
20.00	Vending machines		0		0.00	o	20.00
21. 00	Income from imposition of		0		0.00	0	21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
22.00	overpayments and borrowings to	,	0		0.00	Ĭ	22.00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24. 00
	therapy costs in excess of						
25 00	limitation (chapter 14)		^	*** Cost Conton Doloted ***	114 00		25 00
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
	(chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27.00	COSTS-BLDG & FIXT		0	CAR REL COCTO MARRIE FOLLID	2.00		27.00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		Ü	CAP REL COSTS-MVBLE EQUIP	2.00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00	0	29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)						
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	o	32. 00
0.5	Depreciation and Interest		-				
33. 00	MARKETING COST	A	-877	ADMINISTRATIVE & GENERAL	5. 00	l 0	33. 00

				To	12/31/2022	Date/Time Prep 5/25/2023 5:4	
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
34.00	REFUND OF EMP BENEFITS	В	·	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	34.00
35.00	MISC OTHER OPERATING REVENUE	В	·	ADMINISTRATIVE & GENERAL	5. 00	0	35. 00
36.00	PATIENT ACCOUNTING INTEREST	В	·	ADMINISTRATIVE & GENERAL	5. 00	0	36.00
37. 00	CHGME REV	В		ADULTS & PEDIATRICS	30.00		37. 00
38. 00	NURSE PRACTITIONER SALARIES	A		MEDICAL SERVICES	76. 00		38. 00
39. 00	NURSE PRAC BENEFITS	A	-621, 307	EMPLOYEE BENEFITS DEPARTMENT	4. 00		39. 00
40. 00	PHYSICIAN PART C	A	-30, 438	ADULTS & PEDIATRICS	30.00	0	40. 00
41.00	PHYSICIAN PART C	A	-30, 557	CLINIC	90.00	0	41. 00
43.00	PHYSICIAN PART C	A	-13, 709	PSYCHI ATRI C	76. 01	0	43.00
44.00	PEDI CATRI C PRACTI CE	В	-1, 296	CLINIC	90.00	0	44.00
45.00	CEPHALON DRUG TRIAL	В	-60, 467	PSYCHI ATRI C	76. 01	0	45. 00
50.00	TOTAL (sum of lines 1 thru 49)		-6, 143, 151				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

- (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.

\* 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.

13, 857, 032

10, 799, 402

5.00

 be been posted to not kender h, cordinate a day or 2, the amount arrowable should be that dated the cordinate of this part.									
			Related Organization(s) and/	or Home Office					
Symbol (1)	Name	Percentage of	Name	Percentage of					
		Ownershi p		Ownershi p					
1. 00	2. 00	3. 00	4. 00	5. 00					
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME 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	A	0.00 RWJ BARNABAS HEALTH 100.00	6. 00
7.00		0.00	7. 00
8.00		0.00	8. 00
9. 00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (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.

5.00

line 12.

TOTALS (sum of lines 1-4).

Transfer column 6, line 5 to Worksheet A-8, column 2,

Heal th	Financial Syste	ems	CHILDRENS SPECIALIZED HOPSITAL			In Lieu of Form CMS-2552-1			
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGANIZA	ATIONS AND HOME	Provider CCN:	31-3300	Peri od:	Worksheet A-	8-1
OFFICE	COSTS						From 01/01/2022		
							To 12/31/2022	Date/Time Pro	
	No+	Wko+ A 7 Dof		<u> </u>			L	5/25/2023 5:	49 piii
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REQUIRED AS	S A RESULT OF TRA	NSACTIONS WITH	RELATED O	RGANIZATIONS OR (	CLAI MED	
	HOME OFFICE CO	STS:							
1.00	3, 057, 630	0							1.00
2.00	0	0							2.00
3.00	0	0							3.00
4.00	0	0							4.00
5.00	3, 057, 630								5. 00
* The	amounts on lin	es 1-4 (and sub	scripts as appro	nriate) are tran	sferred in deta	il to Worl	ksheet A, column	6 lines as	
							ganization or hom		whi ch
							ated in column 4		
	· · · · · · · · · · · · · · · · · · ·	ani zati on(s)							
		me Office							
	and/or Ho	me Office							

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.

	HEALTHCARE	6. 00
7.00	1	7. 00
8.00	1	8. 00
9.00	!	9. 00
10.00	!	10.00
9. 00 10. 00 100. 00		100.00

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

Type of Business

- 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.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT | Peri od: | Worksheet A-8-2 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: | D Provider CCN: 31-3300

					1	o 12/31/2022	2   Date/Time Pro   5/25/2023 5:4	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00	30.00	AGGREGATE-ADULTS &	819, 817	647, 079	172, 738	211, 500	1, 556	1. 00
	F	PEDI ATRI CS						
2.00		AGGREGATE-PSYCHI ATRI C	1, 211, 144			211, 500		
3. 00		AGGREGATE-CLINIC	3, 971, 465			211, 500		
4.00	0.00		0		0	0	0	
5. 00	0.00		0	l	0	0	0	0.00
6. 00	0.00		0	0	0	0	0	
7. 00	0. 00		0	0	0	0	0	
8.00	0. 00		0	0	0	0	0	
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 1 0 1 (D)	6, 002, 426			5	10, 410	200. 00
	Wkst. A Line #	<b>3</b>	Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng Educati on	Share of col. 12	Insurance	
	1. 00	2. 00	8.00	9. 00	12. 00	13. 00	14.00	
1.00		AGGREGATE-ADULTS &	158, 218					1. 00
1.00		PEDI ATRI CS	130, 210	7, 711	J	0	Ĭ	1.00
2.00		AGGREGATE-PSYCHI ATRI C	201, 128	10, 056	0	0	0	2.00
3. 00		AGGREGATE-CLI NI C	699, 170			0	Ö	
4.00	0.00		0			0	0	4. 00
5.00	0.00		0	0	0	0	0	5. 00
6.00	0.00		0	0	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9. 00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			1, 058, 516	52, 926	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldentifier	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	0.00	14	1/ 00	47.00	10.00		
1 00	1. 00	2.00	15. 00	16.00	17. 00	18.00		1.00
1. 00		AGGREGATE-ADULTS & PEDIATRICS	0	158, 218	14, 520	661, 599		1. 00
2. 00		AGGREGATE-PSYCHI ATRI C	0	201, 128	33, 166	1, 010, 016		2. 00
3.00		AGGREGATE-F3TCHTATKTC				3, 272, 295		3. 00
4.00	0.00	AGGREGATE-CETIVI C		077, 170		3, 272, 293		4.00
5.00	0.00			0	, and the second	0		5. 00
6. 00	0.00				0	0		6.00
7. 00	0.00			0	0	0		7. 00
8.00	0.00				n	0		8.00
9. 00	0.00				n	0		9. 00
10. 00	0.00		0		n	0		10.00
200.00	3.00		0	1	71, 059	_		200.00
	1		1	., .,	, ,	.,	1	

COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der CO	eri od:	Worksheet B		
				F	rom 01/01/2022 o 12/31/2022	Part I	
				T	o 12/31/2022	Date/Time Pre	
			CAPI TAL REL	ATED COSTS		5/25/2023 5: 4	9 DIII
			CAFITAL KLL	AILD COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	oust defiter beschiptron	for Cost	DEDO U TIXI	MVDLL LQOIT	BENEFI TS	odbtotai	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7)					
		0	1. 00	2.00	4. 00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	5, 185, 022	5, 185, 022				1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1, 431, 610		1, 431, 610			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	21, 438, 301	14, 632	4, 040	21, 456, 973		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	44, 272, 710	1, 616, 160	446, 232	3, 041, 342	49, 376, 444	5. 00
7. 00	00700 OPERATION OF PLANT	4, 560, 982	263, 919	72, 869	489, 613	5, 387, 383	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8. 00
9.00	00900 HOUSEKEEPI NG	2, 132, 676	33, 777	9, 326	295, 696	2, 471, 475	9. 00
10.00	01000 DI ETARY	2, 056, 283	111, 582	30, 808	260, 325	2, 458, 998	
13.00	01300 NURSI NG ADMI NI STRATI ON	44, 216	0	0	4, 042	48, 258	
15.00	01500 PHARMACY	1, 704, 554	23, 115	6, 382	313, 728	2, 047, 779	
16.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	1, 032, 466	57, 999	16, 014	186, 749	1, 293, 228	
17. 00 18. 00	01080 I NSERVI CE EDUCATI ON	121, 916 27, 951	8, 303	2, 292	23, 754	156, 265	17. 00 18. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	27, 951	11, 143 0	3, 077 0	2, 814 0	44, 985 0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	977, 413	0	0	0	977, 413	
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	7/1,413	U	U	U	7/1,413	22.00
30. 00	03000 ADULTS & PEDI ATRI CS	17, 876, 203	515, 517	142, 337	3, 723, 693	22, 257, 750	30. 00
44. 00	04400 SKI LLED NURSI NG FACI LI TY	8, 081, 104	337, 332	93, 139	1, 592, 759	10, 104, 334	44. 00
45. 00	04500 NURSING FACILITY	4, 811, 370	0	0	777, 191	5, 588, 561	45. 00
10.00	ANCILLARY SERVICE COST CENTERS	1,011,070			,,,,	0,000,001	10.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 212	578	159	0	5, 949	54.00
60.00	06000 LABORATORY	31, 601	0	0	0	31, 601	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65.00	06500 RESPIRATORY THERAPY	3, 607, 407	11, 106	3, 067	541, 914	4, 163, 494	65. 00
66.00	06600 PHYSI CAL THERAPY	5, 470, 856	439, 312	121, 296	997, 464	7, 028, 928	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	6, 329, 560	379, 147	104, 684	1, 190, 012	8, 003, 403	67. 00
68.00	06800 SPEECH PATHOLOGY	7, 209, 688	337, 790	93, 265	1, 260, 200	8, 900, 943	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 715, 377	0	0	0	2, 715, 377	71. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	689, 507	0	0	0	689, 507	73. 00
76. 00	03550 MEDI CAL SERVI CES	2, 822, 113	18, 254	5, 040	1, 391, 382	4, 236, 789	76. 00
76. 01	03950 PSYCHI ATRI C	6, 358, 887	471, 741	130, 250	1, 423, 431	8, 384, 309	76. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
00 00	OUTPATIENT SERVICE COST CENTERS	7 220 542	240 772	00 (11	1 500 021	0.204.040	00 00
90.00	09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART	7, 238, 543	360, 773	99, 611	1, 588, 021	9, 286, 948	
92. 00 93. 00		10, 887, 978	170 040	47 700	2 140 000	12 257 421	92. 00 93. 00
	04950   SCHOOL BASED PROGRAMS   09399   PARTI AL HOSPI TALI ZATI ON PROGRAM	10, 887, 978	172, 842	47, 722	2, 149, 089 0	13, 257, 631	93.00
93. 99	OTHER REIMBURSABLE COST CENTERS	U U	0	0	U	U	93. 99
102.00	10200 OPI OI D TREATMENT PROGRAM	O	0	0	0	0	102. 00
102.00	SPECIAL PURPOSE COST CENTERS	U U	U	U	U	0	102.00
113 00	11300 I NTEREST EXPENSE						113. 00
118. 00		169, 121, 506	5, 185, 022	1, 431, 610	21, 253, 219	168, 917, 752	
110.00	NONREI MBURSABLE COST CENTERS	107, 121, 300	3, 103, 022	1, 431, 010	21, 255, 217	100, 717, 732	110.00
191 00	19100 RESEARCH	2, 042, 890	0	n	203, 754	2, 246, 644	191. 00
	07950 CHILD CARE CENTER (MEDICAL DAY CARE	2,312,370	0	0	200, 704		194. 00
200.00			J	Ü	Ĭ		200.00
201.00			0	0	0		201. 00
202.00		171, 164, 396	5, 185, 022	1, 431, 610	21, 456, 973	171, 164, 396	
							•

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2022 Part I
To 12/31/2022 Date/Time Prepared: 5/25/2023 5:49 pm

				'	0 12/01/2022	5/25/2023 5: 4	9 pm
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	49, 376, 444					5. 00
7. 00	00700 OPERATION OF PLANT	2, 184, 207	7, 571, 590				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	2, 104, 207	7, 371, 390	΄.			8.00
9. 00		1 002 010	77 704	′	2 551 211		9.00
	00900 HOUSEKEEPI NG	1, 002, 010	77, 726		0,00.,2	0 004 000	
10.00	01000 DI ETARY	996, 952	256, 770	1	121,077	3, 834, 399	10.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	19, 565	0		1	0	13. 00
15. 00	01500 PHARMACY	830, 231	53, 193		,	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	524, 313	133, 466		63, 247	0	16. 00
17. 00	01700 SOCIAL SERVICE	63, 355	19, 106	o  C	9, 054	0	17. 00
18.00	01080 I NSERVI CE EDUCATI ON	18, 238	25, 641		12, 151	0	18. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	) c	0	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	396, 273	0	ol c	ol	0	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · ·		•	'		
30.00	03000 ADULTS & PEDIATRICS	9, 023, 916	1, 186, 295	i c	562, 165	1, 766, 165	30. 00
44. 00	04400 SKILLED NURSING FACILITY	4, 096, 600	776, 262			1, 409, 713	44. 00
45. 00	04500 NURSING FACILITY	2, 265, 770	7,70,202	1		658, 521	45. 00
10.00	ANCILLARY SERVICE COST CENTERS	2,200,770		1	,ı	000,021	10.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 412	1, 329		630	0	54.00
60. 00	06000 LABORATORY	12, 812	1, 327	1		0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	12, 612	0			0	62. 30
			25 550		12 11	0	
65. 00	06500 RESPI RATORY THERAPY	1, 688, 005	25, 558		12, 111	•	65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 849, 738	1, 010, 935	1	,	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	3, 244, 820	872, 485	1	1.07.00	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	3, 608, 709	777, 315		, 000, 000	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 100, 895	0	)  C	0	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	279, 547	0	)  C	′I "I	0	73. 00
76. 00	03550 MEDI CAL SERVI CES	1, 717, 721	42, 006	o C	19, 906	0	76. 00
76. 01	03950 PSYCHI ATRI C	3, 399, 250	1, 085, 560	) C	514, 428	0	76. 01
76. 97	07697 CARDIAC REHABILITATION	0	0	) C	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	O	0	) c	o	0	76. 98
76. 99	07699 LI THOTRI PSY	o	0		ol	0	76. 99
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	l ol	0		ol	0	77. 00
	OUTPATIENT SERVICE COST CENTERS	-					
90.00	09000 CLI NI C	3, 765, 207	830, 203	s c	393, 418	0	90.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0,700,207	000, 200	1	070, 110	Ü	92.00
93. 00	04950 SCHOOL BASED PROGRAMS	5, 375, 041	397, 740		188, 482	0	93. 00
93. 00	09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0, 373, 041	397, 740			0	93. 00
93. 99	OTHER REIMBURSABLE COST CENTERS	l ol		'	, U	U	93.99
400.00					, al		400 00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	) <u> </u>	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
118.00	, , , , , , , , , , , , , , , , , , , ,	48, 465, 587	7, 571, 590	) C	3, 551, 211	3, 834, 399	118. 00
	NONREI MBURSABLE COST CENTERS						
	19100 RESEARCH	910, 857	0	0	0		191. 00
194.00	07950 CHILD CARE CENTER (MEDICAL DAY CARE	0	0	) C	0	0	194. 00
200.00	Cross Foot Adjustments						200. 00
201.00		O	0	) c	ol ol	0	201. 00
202.00	1 9	49, 376, 444	7, 571, 590		3, 551, 211	3, 834, 399	202. 00
	1 1 3			1		-,,	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part I | To 12/31/2022 | Date/Time Prepared: | 5/25/2023 5:49 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 31-3300

						5/25/2023 5: 4	9 pm
	·		·			OTHER GENERAL	
						SERVI CE	
	Cost Center Description	NURSI NG	PHARMACY	MEDI CAL	SOCIAL SERVICE		
	5551 5511tol. 25551. pt. 511	ADMI NI STRATI ON		RECORDS &	0001712 021111 02	EDUCATI ON	
		7.Dilli 141 OTTOTT OIL		LI BRARY		EDOGRITTON	
		13. 00	15. 00		17. 00	18. 00	
	CENEDAL CEDALCE COCT CENTEDO	13.00	13.00	16. 00	17.00	16.00	
	GENERAL SERVI CE COST CENTERS	т т					
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10. 00	01000 DI ETARY						10.00
13. 00	01300 NURSING ADMINISTRATION	67, 823					13. 00
		1	2 05/ 410				1
15. 00	01500 PHARMACY	0	2, 956, 410				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	2, 014, 254			16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	247, 780		17. 00
18. 00	01080 I NSERVI CE EDUCATI ON	0	0	0	904	101, 919	18. 00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	-1	-	-	-		
30. 00	03000 ADULTS & PEDI ATRI CS	36, 624	0	161, 140	41, 803	17, 259	30. 00
				·		· ·	
44.00	04400 SKILLED NURSING FACILITY	23, 060	0				44. 00
45. 00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0			19	54.00
60.00	06000 LABORATORY	0	0	0	0	0	60. 00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	l ol	0	0	901	372	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	402, 851	35, 625	14, 707	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		0	· ·			67. 00
68. 00	06800 SPEECH PATHOLOGY		0	· ·			1
71. 00			0				71.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0.05/.440	0			
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	2, 956, 410			0	73. 00
76. 00	03550 MEDI CAL SERVI CES	0	0	0			76. 00
76. 01	03950 PSYCHI ATRI C	0	0	261, 853	38, 255	15, 793	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	o	0	0	0	0	76. 99
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS	-1	-				1
90.00	09000 CLINI C	8, 139	0	382, 708	29, 256	12, 078	90.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0, 137	O	302, 700	27, 250	12,070	92.00
	04200 OBSERVATION BEDS (NON-DISTINCT FART		0	_	14 01/	F 70/	
93. 00	04950 SCHOOL BASED PROGRAMS	0	0	_			93. 00
93. 99	09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0	0	0	0	0	93. 99
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	67, 823	2, 956, 410	2, 014, 254	247, 780	101, 919	118. 00
	NONREI MBURSABLE COST CENTERS	2.,020	_, ,	_,_,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		, , , , ,	1
191 00	19100 RESEARCH	O	0	0	0	n	191. 00
	07950 CHILD CARE CENTER (MEDICAL DAY CARE		0				194. 00
200.00		١	U	l "			
	1 1			_		_	200.00
201.00	1 9	0	0 657 75	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	67, 823	2, 956, 410	2, 014, 254	247, 780	101, 919	202.00

Health Financial Systems CHILDRENS SPECIALIZED HOPSITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 31-3300 Peri od: Worksheet B From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/25/2023 5:49 pm INTERNS & RESIDENTS Cost Center Description SERVI CES-SALAR SERVI CES-OTHER Subtotal Intern & Total Y & FRINGES PRGM COSTS Residents Cost APPRV **APPRV** & Post Stepdown Adjustments 21. 00 22.00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI FTARY 10 00 10 00 13.00 01300 NURSING ADMINISTRATION 13.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16, 00 01700 SOCIAL SERVICE 17.00 17.00 18.00 01080 INSERVICE EDUCATION 18.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV I NPATI ENT ROUTI NE SERVI CE COST CENTERS 1, 373, 686 22.00 22.00 35, 053, 117 30.00 03000 ADULTS & PEDIATRICS 0 35, 619, 494 -566, 377 30.00 566, 377 44.00 04400 SKILLED NURSING FACILITY 0 16, 897, 044 16, 897, 044 44.00 04500 NURSING FACILITY 45.00 0 0 8, 512, 852 8, 512, 852 45.00 0 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 10, 386 10, 386 54.00 54.00 60.00 06000 LABORATORY 0 0 0 60.00 44.413 44.413 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 0 C 0 62.30 65.00 06500 RESPIRATORY THERAPY r 5, 890, 441 0 5, 890, 441 65.00 06600 PHYSI CAL THERAPY 11, 821, 849 66.00 000000 442, 128 12, 263, 977 -442, 128 66.00 06700 OCCUPATIONAL THERAPY 0 13, 101, 309 0 13, 101, 309 67.00 06800 SPEECH PATHOLOGY 13, 895, 448 0 13, 895, 448 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3, 816, 272 0 3, 816, 272 71.00 0 07300 DRUGS CHARGED TO PATIENTS 0 3, 925, 464 3, 925, 464 73.00 03550 MEDICAL SERVICES 6, 018, 513 6, 018, 513 76.00 0 03950 PSYCHI ATRI C 13, 699, 448 13, 699, 448 76.01 0 07697 CARDIAC REHABILITATION 76. 97 0 0 0 0 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 0 0 0 07699 LI THOTRI PSY Λ 0 76. 99 Λ 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-3300

				10	12/31/2022	Date/lime Pre 5/25/2023 5:4	
			CAPI TAL REI	LATED COSTS		372372023 3.4	) piii
	Cost Center Description	Di rectl y	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	U	1.00	2.00	ZA	4.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	14, 632	4, 040	18, 672	18, 672	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	0	1, 616, 160		2, 062, 392	2, 646	5. 00
7. 00	00700 OPERATION OF PLANT	0	263, 919		336, 788	426	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8. 00
9. 00	00900 HOUSEKEEPI NG	0	33, 777		43, 103	257	9. 00
10.00	01000 DI ETARY	0	111, 582		142, 390	226	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	_	0 407	4	13.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	23, 115 57, 999		29, 497 74, 013	273 162	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	8, 303		10, 595	21	17. 00
18. 00	01080 I NSERVI CE EDUCATI ON	0	11, 143		14, 220	2	18.00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	11, 143		0	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	Ö		Ö	0	22. 00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		22.00
30.00	03000 ADULTS & PEDI ATRI CS	0	515, 517	142, 337	657, 854	3, 246	30.00
44.00	04400 SKILLED NURSING FACILITY	0	337, 332	93, 139	430, 471	1, 386	44.00
45.00	04500 NURSING FACILITY	0	0	0	o	676	45. 00
	ANCILLARY SERVICE COST CENTERS						
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	578		737	0	54. 00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	11 10/	0	14 172	0	62. 30
65. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	11, 106		14, 173	471	65.00
66. 00 67. 00	06700 OCCUPATI ONAL THERAPY	0	439, 312 379, 147		560, 608 483, 831	868 1, 035	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	377, 147		431, 055	1, 035	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	337, 790	73, 203	431,033	1, 090	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		Ö	0	73. 00
76. 00	03550 MEDI CAL SERVI CES	0	18, 254	5, 040	23, 294	1, 210	ı
76. 01	03950 PSYCHI ATRI C	0	471, 741		601, 991	1, 238	1
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	О	o	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLINIC	0	360, 773	99, 611	460, 384	1, 382	90. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		470 040	47.700	0	4 070	92.00
93. 00	04950 SCHOOL BASED PROGRAMS	0	172, 842		220, 564	1, 870	1
93. 99	O9399   PARTI AL HOSPI TALI ZATI ON PROGRAM   OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	93. 99
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	1 102. 00
102.00	SPECIAL PURPOSE COST CENTERS	U	0	<u> </u>	<u>U</u>		102.00
113.00	11300 I NTEREST EXPENSE						113. 00
118.00		0	5, 185, 022	1, 431, 610	6, 616, 632	18. 495	118. 00
	NONREI MBURSABLE COST CENTERS	,				-, -, -, -	
191.00	19100 RESEARCH	0	0	0	0	177	191. 00
	07950 CHILD CARE CENTER (MEDICAL DAY CARE	0	0	0	o	0	194. 00
200.00	1 1				0		200. 00
201.00			0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	0	5, 185, 022	1, 431, 610	6, 616, 632	18, 672	202. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-3300

				11	0 12/31/2022	Date/lime Pre   5/25/2023 5:4	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	7 DIII
	oust defiter beschiptron	& GENERAL	PLANT	LINEN SERVICE	HOUSEKEEL THO	DIEMMI	
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	2, 065, 038					5. 00
7.00	00700 OPERATION OF PLANT	91, 348	428, 562				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0			8. 00
9.00	00900 HOUSEKEEPI NG	41, 906	4, 399		89, 665		9. 00
10.00	01000 DI ETARY	41, 695	14, 533		3, 072	201, 916	
13.00	01300 NURSI NG ADMI NI STRATI ON	818	0	0	0	0	
15. 00	01500 PHARMACY	34, 722	3, 011	0	636	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	21, 928	7, 554	0	1, 597	0	16. 00
17. 00	01700 SOCIAL SERVICE	2, 650	1, 081	0	229	0	
18. 00	01080 I NSERVI CE EDUCATI ON	763	1, 451	0	307	0	18. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	_	0	0	
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	16, 573	0	0	0	0	22. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	077 405		1		00.005	
30.00	03000 ADULTS & PEDI ATRI CS	377, 405	67, 147		14, 194	93, 005	
44.00	04400 SKILLED NURSING FACILITY	171, 329	43, 937		9, 288	74, 234	44. 00
45. 00	04500 NURSING FACILITY	94, 760	0	0	0	34, 677	45. 00
F4 00	ANCI LLARY SERVI CE COST CENTERS	101	7.5	1 0	47	0	F4 00
54. 00 60. 00	05400   RADI OLOGY-DI AGNOSTI C   06000   LABORATORY	101 536	75 0		16 0	0	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	530	0		0	0	62. 30
65. 00	06500 RESPIRATORY THERAPY	70, 596	1, 447	_	306	0	65.00
66. 00	06600 PHYSI CAL THERAPY	119, 183	57, 220		12, 096	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	135, 706	49, 384		10, 439	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	150, 924	43, 997		9, 301	0	68.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	46, 042	13, 777		7, 301	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	11, 691	0	_	0	0	
76. 00	03550 MEDI CAL SERVI CES	71, 839	2, 378	_	503	0	76.00
76. 01	03950 PSYCHI ATRI C	142, 164	61, 444		12, 989	0	76. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	O	0	76, 98
76. 99	07699 LI THOTRI PSY	0	0	0	O	0	76. 99
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	157, 469	46, 991	0	9, 933	0	90. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950 SCHOOL BASED PROGRAMS	224, 796	22, 513	0	4, 759	0	93. 00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93. 99
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
118.00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	2, 026, 944	428, 562	0	89, 665	201, 916	118. 00
	NONREI MBURSABLE COST CENTERS			,			
	19100 RESEARCH	38, 094	0		0		191. 00
	07950 CHILD CARE CENTER (MEDICAL DAY CARE	0	0	0	0	0	194. 00
200.00	1 1		_	_	_	=	200.00
201.00		0	420.543	0	00 ((5		201. 00
202. 00	TOTAL (sum lines 118 through 201)	2, 065, 038	428, 562	0	89, 665	201, 916	J2U2. UU

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | T Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-3300

				1'	0 12/31/2022	5/25/2023 5: 4	
						OTHER GENERAL	7 5
						SERVI CE	
	Cost Center Description	NURSI NG	PHARMACY	MEDI CAL	SOCIAL SERVICE	I NSERVI CE	
	occi contor boson per on	ADMI NI STRATI ON		RECORDS &	0001712 021111 02	EDUCATI ON	
		7.5		LI BRARY		25007111011	
		13.00	15. 00	16. 00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS	1 10.00					
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPING						9. 00
10. 00	01000 DI ETARY						10.00
13. 00	01300 NURSING ADMINISTRATION	822					13. 00
15. 00	01500 PHARMACY	022	68, 139				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	00, 137				16. 00
17. 00	01700 SOCIAL SERVICE		0				17. 00
18. 00	01080 I NSERVI CE EDUCATI ON		0	_		14 704	
		0	J			16, 796	1
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	0	_	· ·	0	
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			2 422	0 (50)	0.010	
30. 00	03000 ADULTS & PEDI ATRI CS	444	0	· ·		2, 843	1
44. 00	04400 SKILLED NURSING FACILITY	279	0	·		1, 861	44. 00
45. 00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
	ANCILLARY SERVICE COST CENTERS						1
54. 00	05400   RADI OLOGY-DI AGNOSTI C	0	0			3	1
60.00	06000 LABORATORY	0	0			0	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0			0	
65. 00	06500 RESPI RATORY THERAPY	0	0	0	53	61	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	21, 051	2, 096	2, 424	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	27, 367	1, 809	2, 092	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	10, 525	1, 611	1, 864	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	68, 139	0	0	0	73. 00
76.00	03550 MEDI CAL SERVI CES	0	0	0	87	101	76. 00
76. 01	03950 PSYCHI ATRI C	0	0	13, 683	2, 250	2, 603	76. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS	·					1
90.00	09000 CLI NI C	99	0	19, 998	1, 721	1, 990	90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
93.00	04950 SCHOOL BASED PROGRAMS	o	0	0	825	954	93. 00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	o	0			0	1
	OTHER REIMBURSABLE COST CENTERS		-	_	-1		1
102 00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
102.00	SPECIAL PURPOSE COST CENTERS	<u> </u>			<u> </u>		102.00
113 00	11300 I NTEREST EXPENSE						113. 00
118. 00	1 1	822	68, 139	105, 254	14, 576	16 796	118. 00
	NONREI MBURSABLE COST CENTERS	022	00, 137	100, 204	17,570	10, 770	1.10.00
191 00	19100 RESEARCH	ام	0	0	0	0	191. 00
	07950 CHILD CARE CENTER (MEDICAL DAY CARE		0				194. 00
200.00		١	0			0	200. 00
200.00	1 1		^	0	0	^	200.00
201.00		822	68, 139	l ~	ا م ا		201.00
202.00	TOTAL (Sum Times 110 till ough 201)	022	00, 139	105, 254	14,570	10, 790	1202.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-3300 Peri od: Worksheet B From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/25/2023 5:49 pm INTERNS & RESIDENTS Cost Center Description SERVI CES-SALAR SERVI CES-OTHER Subtotal Intern & Total Y & FRINGES PRGM COSTS Residents Cost APPRV APPRV & Post Stepdown Adjustments 21. 00 22.00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FIXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10 00 10 00 13.00 01300 NURSING ADMINISTRATION 13.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16, 00 17.00 01700 SOCIAL SERVICE 17.00 18.00 01080 INSERVICE EDUCATION 18.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV I NPATI ENT ROUTI NE SERVI CE COST CENTERS <u>16</u>, 573 22.00 22.00 30.00 03000 ADULTS & PEDIATRICS 1, 227, 017 1, 227, 017 30.00 44.00 04400 SKILLED NURSING FACILITY 738, 604 0 738, 604 44.00 04500 NURSING FACILITY 130, <u>113</u> 45.00 130, 113 0 45.00 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 935 54.00 935 54.00 0 60.00 06000 LABORATORY 60.00 536 536 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 C 0 06500 RESPIRATORY THERAPY 0 65.00 87, 107 87, 107 65.00 06600 PHYSI CAL THERAPY 775, 546 775, 546 66.00 0 0 0 0 0 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 711, 663 711, 663 67.00 06800 SPEECH PATHOLOGY 68.00 650, 373 650, 373 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 46,042 46,042 71.00 71.00 07300 DRUGS CHARGED TO PATIENTS 73.00 79,830 79,830 73.00 03550 MEDICAL SERVICES 76 00 99.412 99 412 76.00 03950 PSYCHI ATRI C 76.01 838, 362 838, 362 76.01 07697 CARDIAC REHABILITATION 76. 97 76. 97 0 0 0 07698 HYPERBARI C OXYGEN THERAPY 76. 98 76.98 0 0 07699 LI THOTRI PSY 76.99 0 76.99 0 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 699 967 699 967 90 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 93.00 04950 SCHOOL BASED PROGRAMS 476, 281 0 476, 281 93.00 09399 PARTIAL HOSPITALIZATION PROGRAM 93.99 93.99 0 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 6, 561, 788 6, 561, 788 118. 00 0 Ω 0 NONREI MBURSABLE COST CENTERS 38, 271 191. 00 191. 00 19100 RESEARCH 38, 271 0 194. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 194. 00 Cross Foot Adjustments 0 16, 573 200, 00 200.00 16, 573 16.573 201.00 Negative Cost Centers 0 0 0 201. 00 TOTAL (sum lines 118 through 201) 6, 616, 632 202. 00 202.00 16, 573 6, 616, 632

Health Financial Systems CHILDRENS SPECIALIZED HOPSITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 31-3300 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/25/2023 5:49 pm CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description (SOUARE FEET) (SOUARE FEET) BENEFITS & GENERAL DEPARTMENT (ACCUM COST) (GROSS SALARI ES) 1.00 2.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 430 901 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 430, 901 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 216 1, 216 102, 005, 365 4.00 00500 ADMINISTRATIVE & GENERAL 14, 458, 415 5 00 -49, 376, 444 121 787 952 5 00 134 311 134.311 7.00 00700 OPERATION OF PLANT 21, 933 21, 933 2, 327, 601 5, 387, 383 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 2,807 2, 807 1, 405, 726 0 2, 471, 475 9.00 9.00 01000 DI FTARY 1, 237, 572 2, 458, 998 10 00 9.273 9, 273 10 00 13.00 01300 NURSING ADMINISTRATION 19, 216 48, 258 13.00 01500 PHARMACY 1, 921 1, 921 1, 491, 448 2, 047, 779 15.00 15.00 0 01600 MEDICAL RECORDS & LIBRARY 4, 820 887, 795 1, 293, 228 16, 00 4.820 16, 00 01700 SOCIAL SERVICE 17.00 690 690 112, 926 156, 265 17.00 18.00 01080 INSERVICE EDUCATION 926 926 13, 380 0 44, 985 18.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 0 0 21.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVICE COST CENTERS 977, 413 0 0 0 22.00 22.00 30.00 03000 ADULTS & PEDIATRICS 42, 842 42, 842 17, 702, 087 0 22, 257, 750 30.00 44.00 04400 SKILLED NURSING FACILITY 28, 034 28, 034 7, 571, 909 0 10, 104, 334 44.00 04500 NURSING FACILITY 45.00 3, 694, 734 0 5, 588, 561 45.00 0 0 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 5, 949 54.00 48 48 54.00 0 06000 LABORATORY 31, 601 60.00 0 0 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 C 0 0 62.30 65.00 06500 RESPIRATORY THERAPY 923 923 2, 576, 236 0 4, 163, 494 65.00 06600 PHYSI CAL THERAPY 4, 741, 902 66.00 36, 509 36, 509 0 7, 028, 928 66, 00 67.00 06700 OCCUPATIONAL THERAPY 31, 509 31, 509 5, 657, 267 8,003,403 67.00 68.00 06800 SPEECH PATHOLOGY 28.072 28,072 5, 990, 939 8, 900, 943 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2, 715, 377 71.00 0 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 689, 507 73.00 03550 MEDICAL SERVICES 6, 614, 575 4, 236, 789 76 00 1.517 1.517 76.00 76.01 03950 PSYCHI ATRI C 39, 204 39, 204 6, 766, 934 8, 384, 309 76.01 0 07697 CARDIAC REHABILITATION 76. 97 0 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 76.98 0 0 0 ol 07699 LI THOTRI PSY 0 76. 99 76.99 0 Λ 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 90 00 logodol ce enec 29 982 29 982 7 549 385 O 9 286 948 90 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 93.00 04950 SCHOOL BASED PROGRAMS 14.364 14.364 10, 216, 681 13, 257, 631 93.00 09399 PARTIAL HOSPITALIZATION PROGRAM 93.99 93.99 0 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 430, 901 430, 901 -49, 376, 444 119, 541, 308 118. 00 118.00 101, 036, 728 NONREIMBURSABLE COST CENTERS 2, 246, 644 191. 00 191, 00 19100 RESEARCH 968, 637 194. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 194.00 C C Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 5, 185, 022 1, 431, 610 21, 456, 973 49, 376, 444 202. 00 Part I) 203 00 Unit cost multiplier (Wkst. B, Part I) 0 210351 0. 405430 203. 00 12 032977 3. 322364 204.00 Cost to be allocated (per Wkst. B, 18, 672 2, 065, 038 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000183 0. 016956 205. 00 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2)

207.00

NAHE unit cost multiplier (Wkst. D,

Parts III and IV)

207.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 31-3300

					T	o 12/31/2022		
		Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5/25/2023 5: 4 NURSI NG	9 pm
		,	PLANT	LINEN SERVICE		(PATIENT DAYS)		
			(SQUARE FEET)	(SQUARE FEET)			(DIRECT NRSING	
							HRS)	
			7. 00	8. 00	9. 00	10.00	13. 00	
1 00		AL SERVICE COST CENTERS	I		I			1 00
1. 00 2. 00	1	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00		ADMINISTRATIVE & GENERAL						5. 00
7.00	1	OPERATION OF PLANT	273, 441					7. 00
8.00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	0	273, 441				8.00
9. 00 10. 00		DIETARY	2, 807 9, 273	2, 807 9, 273				9. 00 10. 00
13. 00	1	NURSI NG ADMI NI STRATI ON	0	0				13. 00
15.00	01500	PHARMACY	1, 921	1, 921	1, 921	0	0	15. 00
16. 00		MEDICAL RECORDS & LIBRARY	4, 820	l			0	16. 00
17. 00	1	SOCIAL SERVICE INSERVICE EDUCATION	690	l			0	17.00
18. 00 21. 00	1	I &R SERVICES-SALARY & FRINGES APPRV	926	926 0			0 0	18. 00 21. 00
22. 00	1	I &R SERVI CES-OTHER PRGM COSTS APPRV	0	ĺ			Ö	22. 00
		IENT ROUTINE SERVICE COST CENTERS	_	· · · · ·	_			
30. 00		ADULTS & PEDIATRICS	42, 842					30. 00
44. 00		SKILLED NURSING FACILITY	28, 034	l .				44. 00
45. 00		NURSING FACILITY LARY SERVICE COST CENTERS	0	0	0	7, 447	0	45. 00
54. 00		RADI OLOGY-DI AGNOSTI C	48	48	48	0	0	54. 00
60.00	1	LABORATORY	0	0			0	60.00
62. 30		BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1		0	62. 30
65. 00		RESPI RATORY THERAPY	923	923	•		0	65. 00
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	36, 509 31, 509	l			0 0	66. 00 67. 00
68. 00	1	SPEECH PATHOLOGY	28, 072	28, 072			0	68. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			0	71. 00
73. 00	1	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
76. 00		MEDI CAL SERVI CES	1, 517	1, 517	1	0	0	76.00
76. 01 76. 97	1	PSYCHIATRIC CARDIAC REHABILITATION	39, 204	39, 204	39, 204 0		0 0	76. 01 76. 97
76. 98		HYPERBARI C OXYGEN THERAPY	0		0	_	0	76. 98
76. 99	1	LI THOTRI PSY	0	0	0	0	0	76. 99
77. 00		ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
00.00		TIENT SERVICE COST CENTERS	29, 982	20.002	20.002		12	00.00
90. 00 92. 00		OBSERVATION BEDS (NON-DISTINCT PART	29, 982	29, 982	29, 982	0	12	90. 00 92. 00
93. 00	1	SCHOOL BASED PROGRAMS	14, 364	14, 364	14, 364	0	0	•
93. 99	1	PARTIAL HOSPITALIZATION PROGRAM	0	0				93. 99
		REIMBURSABLE COST CENTERS						
102.00		OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
113 00		AL PURPOSE COST CENTERS INTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	273, 441	273, 441	270, 634	43, 362		118. 00
		IMBURSABLE COST CENTERS						
		RESEARCH	0	1				191. 00
194. 00 200. 00		CHILD CARE CENTER (MEDICAL DAY CARE Cross Foot Adjustments	0	0	0	0		194. 00
200.00	1	Negative Cost Centers						200. 00 201. 00
202.00		Cost to be allocated (per Wkst. B,	7, 571, 590	О	3, 551, 211	3, 834, 399		
		Part I)						
203.00	1	Unit cost multiplier (Wkst. B, Part I)	27. 690032	l				
204.00	)	Cost to be allocated (per Wkst. B, Part II)	428, 562	0	89, 665	201, 916	822	204. 00
205.00		Unit cost multiplier (Wkst. B, Part	1. 567292	0. 000000	0. 331315	4. 656520	8. 220000	205. 00
		[11)						
206.00	)	NAHE adjustment amount to be allocated						206. 00
207. 00		(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
207.00	1	Parts III and IV)						207.00
	•	•	•	÷	-		•	

Health Financial Systems CHILDRENS SPECIALIZED HOPSITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 31-3300 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/25/2023 5:49 pm OTHER GENERAL INTERNS & SERVI CE **RESI DENTS PHARMACY** MEDI CAL SOCIAL SERVICE I NSERVI CE Cost Center Description SERVI CES-SALAR Y & FRINGES (COSTED RECORDS & **FDUCATION** REQUIS.) LIBRARY (SQUARE FEET) (SQUARE FEET) **APPRV** (TIME SPENT) (ASSI GNED TIME) 15. 00 16. 00 17.00 18.00 21.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI FTARY 10 00 10 00 13.00 01300 NURSING ADMINISTRATION 13.00 01500 PHARMACY 15.00 100 15.00 01600 MEDICAL RECORDS & LIBRARY 16, 00 100 16, 00 0 ol 01700 SOCIAL SERVICE 253, 930 17.00 Ω 17.00 18.00 01080 INSERVICE EDUCATION 0 0 926 253, 004 18.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 C 17, 424 21.00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVI CE COST CENTERS 0 0 0 22.00 22.00 30.00 03000 ADULTS & PEDIATRICS 0 42, 842 42, 842 7, 184 30.00 44.00 04400 SKILLED NURSING FACILITY 0 28, 034 28, 034 44.00 Ω 04500 NURSING FACILITY 45.00 0 0 0 0 0 45.00 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 48 48 0 54.00 06000 LABORATORY 0 0 60.00 60.00 0 0 0 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 0 0 62.30 65.00 06500 RESPIRATORY THERAPY C 923 923 0 65.00 06600 PHYSI CAL THERAPY 66.00 0 0 20 36, 509 36, 509 5, 608 66.00 67.00 06700 OCCUPATIONAL THERAPY 26 31, 509 31, 509 67.00 0 68.00 06800 SPEECH PATHOLOGY 10 28,072 28.072 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 100 0 0 0 73.00 0 03550 MEDICAL SERVICES 1.517 76 00 C 1.517 Λ 76.00 76. 01 03950 PSYCHI ATRI C 13 39, 204 39, 204 0 76.01 0 07697 CARDIAC REHABILITATION 76. 97 0 0 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 76.98 0 0 0 0 ol 07699 LI THOTRI PSY 0 76. 99 76.99 0 0 Λ 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 0 19 29 982 29 982 4 632 90 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 93.00 04950 SCHOOL BASED PROGRAMS 0 0 14.364 14.364 0 93.00 09399 PARTIAL HOSPITALIZATION PROGRAM 93.99 0 93.99 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 100 253, 930 253, 004 118, 00 100 17, 424 118. 00 NONREIMBURSABLE COST CENTERS 0 191. 00 191, 00 19100 RESEARCH 194. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 194.00 0 C 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 2, 956, 410 2,014,254 247, 780 101, 919 0 202.00 Part I) 203 00 Unit cost multiplier (Wkst. B, Part I) 29, 564, 100000 20, 142, 540000 0 975781 0.402836 0. 000000 203. 00 204.00 Cost to be allocated (per Wkst. B, 68, 139 105, 254 14, 576 16, 796 0 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 681. 390000 1, 052. 540000 0.057402 0.066386 0.000000 205.00 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2)

207.00

NAHE unit cost multiplier (Wkst. D,

Parts III and IV)

207.00

Heal th Financial Systems CHILDRENS SPECIALIZED HOPSITAL In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-3300
From 01/01/2022
To 12/31/2022
Date/Time Prepared: 5/25/2023 5: 49 pm

00017			 From 01/01/2022 To 12/31/2022	Date/Time Prepared:
	Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME) 22.00		5/25/2023 5: 49 pm
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FLXT			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500 ADMINISTRATIVE & GENERAL			5. 00
7. 00 8. 00	OO7OO   OPERATION OF PLANT   OO8OO   LAUNDRY & LINEN SERVICE			7. 00 8. 00
9. 00	00900 HOUSEKEEPING			9. 00
10. 00	01000 DI ETARY			10.00
13.00	01300 NURSING ADMINISTRATION			13.00
15. 00	01500 PHARMACY			15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY			16.00
17. 00 18. 00	01700   SOCI AL SERVI CE   01080   I NSERVI CE EDUCATI ON			17. 00 18. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV			21. 00
	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	17, 424		22.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDI ATRI CS	7, 184		30.00
44. 00	04400 SKILLED NURSING FACILITY	0		44. 00
45. 00	04500 NURSING FACILITY	0		45. 00
54.00	ANCI LLARY SERVI CE COST CENTERS    05400   RADI OLOGY-DI AGNOSTI C	0		54. 00
60.00	06000 LABORATORY	0		60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	o		62. 30
65.00	06500 RESPI RATORY THERAPY	0		65. 00
66. 00	06600 PHYSI CAL THERAPY	5, 608		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0		67. 00
68. 00	06800 SPEECH PATHOLOGY	0		68.00
71. 00 73. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0		71. 00 73. 00
76. 00	03550 MEDI CAL SERVI CES	o		76. 00
76. 01	03950 PSYCHI ATRI C	o		76. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0		76. 98
76. 99 77. 00	07699 LI THOTRI PSY	0		76. 99 77. 00
77.00	07700   ALLOGENEI C STEM CELL ACQUISITION   OUTPATIENT SERVICE COST CENTERS	U		77.00
90. 00	09000 CLINIC	4, 632		90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92. 00
93. 00	04950 SCHOOL BASED PROGRAMS	0		93. 00
93. 99	09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0		93. 99
102.00	OTHER REIMBURSABLE COST CENTERS 10200 OPI OI D TREATMENT PROGRAM	0		102. 00
102.00	SPECIAL PURPOSE COST CENTERS	O <sub>I</sub>		102.00
113.00	11300   NTEREST EXPENSE			113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	17, 424		118. 00
404.00	NONREI MBURSABLE COST CENTERS			101 00
	19100 RESEARCH  07950 CHILD CARE CENTER (MEDICAL DAY CARE	0		191. 00 194. 00
200.00				200. 00
201.00				201. 00
202.00		1, 373, 686		202. 00
	Part I)			
203.00		78. 838728		203. 00
204.00		16, 573		204. 00
205.00	Part II)   Unit cost multiplier (Wkst. B, Part	0. 951159		205. 00
200.00	II)	3. 701107		200.00
206.00				206. 00
207.00	(per Wkst. B-2)			207.00
207. 00	NAHE unit cost multiplier (Wkst. D,   Parts III and IV)			207. 00
	1. 3. 65 3.15	ı		1

Health Financial Systems	CHILDRENS SPECIA	ALIZED HOPSITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 31-3300	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/25/2023 5:4	
		Title	XVIII	Hospi tal	TEFRA	
·				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Cost	s RCF	Total Costs	

					5/25/2023 5: 4	9 pm
		Title	XVIII	Hospi tal	TEFRA	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
·	(from Wkst. B,	Ādj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	35, 053, 117		35, 053, 117	0	35, 053, 117	30.00
44.00 04400 SKILLED NURSING FACILITY	16, 897, 044		16, 897, 044	o	16, 897, 044	44.00
45. 00 04500 NURSING FACILITY	8, 512, 852		8, 512, 852		8, 512, 852	45. 00
ANCILLARY SERVICE COST CENTERS			-, - ,	-1		
54, 00 05400 RADI OLOGY-DI AGNOSTI C	10, 386		10, 386	0	10, 386	54.00
60. 00   06000   LABORATORY	44, 413	l e	44, 413	0	44, 413	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	5, 890, 441	0	5, 890, 441	ol	5, 890, 441	65. 00
66. 00 06600 PHYSI CAL THERAPY	11, 821, 849	0	11, 821, 849		11, 821, 849	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	13, 101, 309		13, 101, 309		13, 101, 309	67. 00
68. 00 06800 SPEECH PATHOLOGY	13, 895, 448		13, 895, 448		13, 895, 448	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 816, 272	l e	3, 816, 272		3, 816, 272	71. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	3, 925, 464		3, 925, 464		3, 925, 464	73. 00
76. 00 03550 MEDI CAL SERVI CES	6, 018, 513	l e	6, 018, 513		6, 018, 513	76. 00
76. 01 03950 PSYCHI ATRI C	13, 699, 448		13, 699, 448		13, 699, 448	76. 00
76. 97   07697   CARDI AC   REHABI LI TATI ON	13, 077, 440		13, 077, 440	0	13, 077, 440	76. 97
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0	76. 97 76. 98
76. 99 07699 LI THOTRI PSY	0		0	0	0	76. 98 76. 99
	0		0	U	0	
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0		0	U	U	77. 00
OUTPATIENT SERVICE COST CENTERS	14 707 057		14 707 057	ما	14 707 057	00 00
90. 00   09000   CLINIC	14, 707, 957		14, 707, 957	0	, ,	90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93. 00 04950 SCHOOL BASED PROGRAMS	19, 238, 696		19, 238, 696	0	19, 238, 696	93. 00
93. 99 09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0		0	0	0	93. 99
OTHER REIMBURSABLE COST CENTERS	1					
102. 00 10200 OPI OI D TREATMENT PROGRAM	0		0		0	102. 00
SPECIAL PURPOSE COST CENTERS	1	1				
113. 00 11300 INTEREST EXPENSE		_		_		113. 00
200.00 Subtotal (see instructions)	166, 633, 209	0	166, 633, 209	이	166, 633, 209	
201.00 Less Observation Beds	0		0			201. 00
202.00   Total (see instructions)	166, 633, 209	0	166, 633, 209	0	166, 633, 209	202. 00

Health Financial Systems	CHILDRENS SPECIALIZED HOPSITAL	In Lie	ieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 31-3300	Peri od:	Worksheet C		

From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: 5/25/2023 5:49 pm Title XVIII Hospi tal TEFRA Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 84, 294, 581 84, 294, 581 03000 ADULTS & PEDIATRICS 30.00 30.00 44.00 04400 SKILLED NURSING FACILITY 37, 255, 839 37, 255, 839 44.00 04500 NURSING FACILITY 45.00 45.00 ANCILLARY SERVICE COST CENTERS 54.00 45, 956 42, 400 0.117547 0.117547 54 00 05400 RADI OLOGY-DI AGNOSTI C 88.356 60.00 06000 LABORATORY 919, 403 63, 211 982, 614 0.045199 0.045199 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0.000000 62.30 06500 RESPIRATORY THERAPY 19, 201 25, 564, 537 25, 583, 738 0.230242 0.230242 65.00 65.00 3, 991, 155 17, 228, 956 0.686162 66.00 06600 PHYSI CAL THERAPY 13, 237, 801 0.686162 66.00 67.00 06700 OCCUPATIONAL THERAPY 4, 284, 449 17, 839, 334 22, 123, 783 0.592182 0.592182 67.00 68.00 06800 SPEECH PATHOLOGY 5, 578, 005 20, 128, 889 25, 706, 894 0.540534 0.540534 68.00 2, 495, 856 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2.040.544 1.529043 71.00 455, 312 1.529043 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 918, 515 394, 527 3, 313, 042 1.184852 1.184852 73.00 03550 MEDICAL SERVICES 281, 692 281, 692 21. 365580 21. 365580 76.00 76.00 76. 01 03950 PSYCHI ATRI C 441, 366 20, 168, 251 20, 609, 617 0.664711 0.664711 76.01 07697 CARDIAC REHABILITATION 0.000000 0.000000 76.97  $\cap$ 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 C 0 0.000000 0.000000 76. 98 07699 LI THOTRI PSY 0 0.000000 0.000000 76. 99 76. 99 0 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 0.000000 77.00 77.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 26, 222 26, 138, 941 26, 165, 163 0.562120 0.562120 90.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 0.000000 92.00 93 00 04950 SCHOOL BASED PROGRAMS O 0.000000 0.000000 93 00 0 C 09399 PARTIAL HOSPITALIZATION PROGRAM 93.99 0 0 0 0.000000 0.000000 93.99 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 167, 642, 264 98, 487, 867 266, 130, 131 200.00 201 00 Less Observation Beds 201 00 202.00 Total (see instructions) 167, 642, 264 98, 487, 867 266, 130, 131 202.00

				5/25/2023 5:49 pm
		Title XVIII	Hospi tal	TEFRA
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00  03000 ADULTS & PEDIATRICS				30.00
44.00  04400 SKILLED NURSING FACILITY				44. 00
45.00 04500 NURSING FACILITY				45. 00
ANCI LLARY SERVI CE COST CENTERS				
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 117547			54. 00
60. 00   06000   LABORATORY	0. 045199			60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPI RATORY THERAPY	0. 230242			65. 00
66. 00  06600 PHYSI CAL THERAPY	0. 686162			66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0. 592182			67. 00
68. 00   06800   SPEECH PATHOLOGY	0. 540534			68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 529043			71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1. 184852			73. 00
76. 00   03550   MEDI CAL   SERVI CES	21. 365580			76. 00
76. 01  03950  PSYCHI ATRI C	0. 664711			76. 01
76. 97   07697   CARDI AC REHABI LI TATI ON	0. 000000			76. 97
76. 98   07698   HYPERBARI C OXYGEN THERAPY	0. 000000			76. 98
76. 99   07699   LI THOTRI PSY	0. 000000			76. 99
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 562120			90. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
93.00 04950 SCHOOL BASED PROGRAMS	0. 000000			93. 00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000			93. 99
OTHER REIMBURSABLE COST CENTERS				
102.00 10200 OPIOLD TREATMENT PROGRAM				102. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	CHI LDRENS SPECIA	ALIZED HOPSITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CC	CN: 31-3300	Peri od: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/25/2023 5:4	
		Ti tl	e XIX	Hospi tal	TEFRA	<u> </u>
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	s RCF	Total Costs	

						5/25/2023 5: 4	
			Ti tl	e XIX	Hospi tal	TEFRA	
	·				Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	PATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	35, 053, 117		35, 053, 11	7 14, 520	35, 067, 637	1
	400 SKILLED NURSING FACILITY	16, 897, 044		16, 897, 04		16, 897, 044	1
	500 NURSING FACILITY	8, 512, 852		8, 512, 85	2 0	8, 512, 852	45. 00
	CILLARY SERVICE COST CENTERS						
	400 RADI OLOGY-DI AGNOSTI C	10, 386		10, 38		10, 386	1
	000 LABORATORY	44, 413		44, 41	3 0	44, 413	1
	250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0	0	62. 30
	500 RESPI RATORY THERAPY	5, 890, 441	0			5, 890, 441	65. 00
	600 PHYSI CAL THERAPY	11, 821, 849	0	11, 821, 84		11, 821, 849	1
1	700 OCCUPATI ONAL THERAPY	13, 101, 309	0	13, 101, 30		13, 101, 309	
	800 SPEECH PATHOLOGY	13, 895, 448	0	13, 895, 44		13, 895, 448	1
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 816, 272		3, 816, 27		3, 816, 272	1
	300 DRUGS CHARGED TO PATIENTS	3, 925, 464		3, 925, 46		3, 925, 464	
	550 MEDI CAL SERVI CES	6, 018, 513		6, 018, 51		6, 018, 513	
	950 PSYCHI ATRI C	13, 699, 448		13, 699, 44	8 33, 166	13, 732, 614	1
	697 CARDI AC REHABI LI TATI ON	0			0	0	76. 97
	698 HYPERBARI C OXYGEN THERAPY	0			0	0	
	699 LI THOTRI PSY	0			0 0	0	
	700 ALLOGENEIC STEM CELL ACQUISITION	0			0 0	0	77. 00
	TPATIENT SERVICE COST CENTERS						
	0000 CLI NI C	14, 707, 957		14, 707, 95	7 23, 373	14, 731, 330	
	200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92. 00
	950 SCHOOL BASED PROGRAMS	19, 238, 696		19, 238, 69	6 0	19, 238, 696	
	399 PARTIAL HOSPITALIZATION PROGRAM	0			0	0	93. 99
	HER REIMBURSABLE COST CENTERS						
	200 OPIOID TREATMENT PROGRAM	0			0	0	102. 00
	ECIAL PURPOSE COST CENTERS						
	300 I NTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	166, 633, 209	0	166, 633, 20	9 71, 059		
201. 00	Less Observation Beds	0			0		201. 00
202. 00	Total (see instructions)	166, 633, 209	0	166, 633, 20	9 71, 059	166, 704, 268	202. 00

Health Financial Systems	CHILDRENS SPECIALIZED HOPSITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 31-3300	Peri od:	Worksheet C

From 01/01/2022 To 12/31/2022 Part I Date/Time Prepared: 5/25/2023 5:49 pm Title XIX Hospi tal TEFRA Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 84, 294, 581 84, 294, 581 03000 ADULTS & PEDIATRICS 30.00 30.00 44.00 04400 SKILLED NURSING FACILITY 37, 255, 839 37, 255, 839 44.00 04500 NURSING FACILITY 45.00 45.00 ANCILLARY SERVICE COST CENTERS 54.00 45, 956 42, 400 0.117547 0.117547 54 00 05400 RADI OLOGY-DI AGNOSTI C 88.356 60.00 06000 LABORATORY 919, 403 63, 211 982, 614 0.045199 0.045199 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0.000000 62.30 06500 RESPIRATORY THERAPY 19, 201 25, 564, 537 25, 583, 738 0.230242 0.230242 65.00 65.00 06600 PHYSI CAL THERAPY 3, 991, 155 17, 228, 956 0.686162 66.00 13, 237, 801 0.686162 66.00 67.00 06700 OCCUPATIONAL THERAPY 4, 284, 449 17, 839, 334 22, 123, 783 0.592182 0.592182 67.00 68.00 06800 SPEECH PATHOLOGY 5, 578, 005 20, 128, 889 25, 706, 894 0.540534 0.540534 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2.040.544 2, 495, 856 1.529043 1.529043 71.00 455, 312 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 918, 515 394, 527 3, 313, 042 1.184852 1.184852 73.00 03550 MEDICAL SERVICES 281, 692 281, 692 21. 365580 21. 365580 76.00 76.00 76. 01 03950 PSYCHI ATRI C 441, 366 20, 168, 251 20, 609, 617 0.664711 0.664711 76.01 07697 CARDIAC REHABILITATION 0.000000 0.000000 76.97  $\cap$ 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 C 0 0.000000 0.000000 76.98 07699 LI THOTRI PSY 0 0.000000 0.000000 76. 99 76. 99 0 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 0.000000 77.00 77.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 26, 222 26, 138, 941 26, 165, 163 0.562120 0.562120 90.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 0.000000 92.00 93 00 04950 SCHOOL BASED PROGRAMS O 0.000000 0.000000 93 00 0 C 09399 PARTIAL HOSPITALIZATION PROGRAM 93.99 0 0 0 0.000000 0.000000 93.99 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 167, 642, 264 98, 487, 867 266, 130, 131 200.00 201 00 Less Observation Beds 201 00 202.00 Total (see instructions) 167, 642, 264 98, 487, 867 266, 130, 131 202.00

			10 12/31/2022	5/25/2023 5: 49 pm
		Title XIX	Hospi tal	TEFRA
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS				30.00
44.00  04400  SKILLED NURSING FACILITY				44.00
45.00 04500 NURSING FACILITY				45. 00
ANCILLARY SERVICE COST CENTERS				
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00  06000 LABORATORY	0. 000000			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00   06500   RESPI RATORY THERAPY	0. 000000			65. 00
66. 00   06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	NT 0. 000000			71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
76. 00   03550   MEDI CAL   SERVI CES	0. 000000			76. 00
76. 01   03950   PSYCHI ATRI C	0. 000000			76. 01
76. 97   07697   CARDI AC   REHABI LI TATI ON	0. 000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76. 98
76. 99   07699 LI THOTRI PSY	0. 000000			76. 99
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00  09000 CLI NI C	0. 000000			90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PA	RT 0. 000000			92. 00
93.00 04950 SCHOOL BASED PROGRAMS	0. 000000			93. 00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000			93. 99
OTHER REIMBURSABLE COST CENTERS				
102.00 10200 OPIOLD TREATMENT PROGRAM				102. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet C
From 01/01/2022 Part II
To 12/31/2022 Date/Time Prepared: 5/25/2023 5:49 pm

						5/25/2023 5: 4	9 pm
				e XIX	Hospi tal	TEFRA	
	Cost Center Description	Total Cost	Capital Cost			Operating Cost	
		(Wkst. B, Part	(Wkst. B, Part	Net of Capita	I Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
				col . 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	LLARY SERVICE COST CENTERS						
54.00 0540	00 RADI OLOGY-DI AGNOSTI C	10, 386	935	9, 45	1 0	0	54.00
60.00 0600	00 LABORATORY	44, 413	536	43, 87	7 0	0	60.00
62. 30 062	50 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62. 30
65. 00 0650	00 RESPI RATORY THERAPY	5, 890, 441	87, 107	5, 803, 33	4 0	0	65.00
66.00 0660	00 PHYSI CAL THERAPY	11, 821, 849	775, 546	11, 046, 30	3 0	0	66.00
67. 00 0670	OO OCCUPATIONAL THERAPY	13, 101, 309	711, 663	12, 389, 64	6 0	0	67.00
68. 00 0680	OO SPEECH PATHOLOGY	13, 895, 448	650, 373	13, 245, 07	5 0	0	68.00
71. 00   0710	OO MEDICAL SUPPLIES CHARGED TO PATIENT	3, 816, 272	46, 042	3, 770, 23	0 0	0	71.00
73. 00 0730	OO DRUGS CHARGED TO PATIENTS	3, 925, 464	79, 830	3, 845, 63	4 0	0	73.00
76. 00   035!	50 MEDICAL SERVICES	6, 018, 513	99, 412	5, 919, 10	1 0	0	76.00
76. 01   039!	50 PSYCHI ATRI C	13, 699, 448	838, 362	12, 861, 08	6 0	0	76. 01
76. 97 076	97 CARDIAC REHABILITATION	o	0		o o	0	76. 97
76. 98 076	98 HYPERBARIC OXYGEN THERAPY	o	0		o o	0	76. 98
76. 99 076	99 LI THOTRI PSY	o	0		o o	0	76. 99
77. 00 0770	OO ALLOGENEIC STEM CELL ACQUISITION	o	0		o o	0	77.00
OUTF	PATIENT SERVICE COST CENTERS						
90.00 0900	DO CLI NI C	14, 707, 957	699, 967	14, 007, 99	0 0	0	90.00
92. 00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART	0	0		o o	0	92.00
93. 00 049!	50 SCHOOL BASED PROGRAMS	19, 238, 696	476, 281	18, 762, 41	5 0	0	93.00
93. 99 0939	99 PARTIAL HOSPITALIZATION PROGRAM	0	0		o o	0	93. 99
ОТНЕ	ER REIMBURSABLE COST CENTERS						
102.00 1020	OO OPIOID TREATMENT PROGRAM	0	0		0 0	0	102.00
SPE	CLAL PURPOSE COST CENTERS						
113. 00 1130	00 INTEREST EXPENSE						113. 00
200.00	Subtotal (sum of lines 50 thru 199)	106, 170, 196	4, 466, 054	101, 704, 14	2 0	o	200.00
201.00	Less Observation Beds	0	0		o o	o	201. 00
202. 00	Total (line 200 minus line 201)	106, 170, 196	4, 466, 054	101, 704, 14	2 0	0	202. 00
'				•	•		

						5/25/2023 5:49 pm
			Ti tl	e XIX	Hospi tal	TEFRA
	Cost Center Description	Cost Net of	Total Charges	Outpati ent		
		Capital and	(Worksheet C,	Cost to Charg	je	
		Operating Cost	Part I, column	Ratio (col.	6	
		Reducti on	8)	/ col. 7)		
		6. 00	7. 00	8. 00		
ANCII	LLARY SERVICE COST CENTERS					
54.00 0540	O RADI OLOGY-DI AGNOSTI C	10, 386	88, 356	0. 11754	17	54. 00
60.00 0600	O LABORATORY	44, 413	982, 614	0. 04519	99	60.00
62. 30 0625	D BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	00	62. 30
65. 00 0650	O RESPIRATORY THERAPY	5, 890, 441	25, 583, 738	0. 23024	12	65. 00
66.00 0660	O PHYSI CAL THERAPY	11, 821, 849	17, 228, 956	0. 68616	52	66. 00
67. 00 0670	O OCCUPATIONAL THERAPY	13, 101, 309	22, 123, 783	0. 59218	32	67. 00
68. 00 0680	O SPEECH PATHOLOGY	13, 895, 448	25, 706, 894	0. 54053	34	68. 00
71. 00 0710	OMEDICAL SUPPLIES CHARGED TO PATIENT	3, 816, 272	2, 495, 856	1. 52904	13	71.00
73.00 0730	ODRUGS CHARGED TO PATIENTS	3, 925, 464	3, 313, 042	1. 18485	52	73. 00
76. 00 0355	O MEDICAL SERVICES	6, 018, 513	281, 692	21. 36558	30	76. 00
76. 01 0395	O PSYCHI ATRI C	13, 699, 448	20, 609, 617	0. 66471	11	76. 01
76. 97 0769	7 CARDIAC REHABILITATION	0	0	0. 00000	00	76. 97
76. 98 0769	8 HYPERBARIC OXYGEN THERAPY	0	0	0.00000	00	76. 98
	9 LI THOTRI PSY	O	0	0. 00000		76. 99
77. 00 0770	O ALLOGENEIC STEM CELL ACQUISITION	O	0	0. 00000	00	77. 00
OUTP	ATIENT SERVICE COST CENTERS			,		
90.00 0900	O CLI NI C	14, 707, 957	26, 165, 163	0. 56212	20	90.00
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART	0	0	0. 00000	00	92.00
	O SCHOOL BASED PROGRAMS	19, 238, 696	0	0. 00000	00	93. 00
93. 99 0939	9 PARTIAL HOSPITALIZATION PROGRAM	0	0	0. 00000	00	93. 99
OTHE	R REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		•	_	
	O OPIOID TREATMENT PROGRAM	0	0	0.00000	00	102.00
	I AL PURPOSE COST CENTERS					
	O I NTEREST EXPENSE					113. 00
200. 00	Subtotal (sum of lines 50 thru 199)	106, 170, 196	144, 579, 711			200. 00
201. 00	Less Observation Beds	0	0	,		201. 00
202. 00	Total (line 200 minus line 201)	106, 170, 196	144, 579, 711			202. 00
				•	•	

Health Financial Systems	CHILDRENS SPECIA	ALIZED HOPSITAL		In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2022 To 12/31/2022		nared·
				10 12/01/2022	5/25/2023 5: 4	
			XVIII	Hospi tal	TEFRA	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 227, 017		1, 227, 01		<b>l</b>	
44.00   SKILLED NURSING FACILITY	738, 604	l .	738, 60	· ·		
45.00 NURSING FACILITY	130, 113		130, 11	7, 256	17. 93	45. 00
200.00 Total (lines 30 through 199)	2, 095, 734		2, 095, 73	43, 362		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days					
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00 ADULTS & PEDIATRICS	29	1, 781				30. 00
44.00 SKILLED NURSING FACILITY	0	0	)			44. 00
45.00 NURSING FACILITY	0	0	1			45. 00
200.00 Total (lines 30 through 199)	29	1, 781				200. 00

Health Financial Systems	CHILDRENS SPECIALIZ	ZED HOPSITAL		In Lieu of Form CMS-2552-10
ADDODEL ONMENT OF LABORELENT	ANOLILIADY CEDVILOE CADITAL COCTO	D 1 1 00N 04 0000	Tp	W 1 1 D

Health Financial Systems	CHILDRENS SPECIA	ALIZED HOPSITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS			Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Pre 5/25/2023 5:4	
			XVIII	Hospi tal	TEFRA	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS						
54. 00   05400   RADI OLOGY-DI AGNOSTI C	935		•		0	54. 00
60. 00  06000   LABORATORY	536	982, 614	•		1	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	C	0	0.00000		0	62. 30
65. 00 06500 RESPI RATORY THERAPY	87, 107				0	65. 00
66. 00  06600 PHYSI CAL THERAPY	775, 546				292	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	711, 663	22, 123, 783			176	67. 00
68. 00   06800   SPEECH PATHOLOGY	650, 373	25, 706, 894			284	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	46, 042			·7 0	0	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	79, 830	3, 313, 042	0. 02409	2, 743	66	73. 00
76. 00   03550   MEDI CAL   SERVI CES	99, 412	281, 692	0. 35291	0 0	0	76. 00
76. 01   03950   PSYCHI ATRI C	838, 362	20, 609, 617	0. 04067	'8 0	0	76. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	C	0	0.00000	0 0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	C	0	0.00000	0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	C	0	0.00000	0 0	0	76. 99
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	C	0	0.00000	0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	699, 967	26, 165, 163	0. 02675	52 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	C	0	0.00000	0 0	0	92.00
93.00 04950 SCHOOL BASED PROGRAMS	476, 281	0	0.00000	0 0	0	93. 00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	C	0	0. 00000	0 0	0	93. 99
200.00   Total (lines 50 through 199)	4, 466, 054	144, 579, 711		28, 639	819	200. 00

Health Financial Systems	CHILDRENS SPECIAL	IZED HOPSITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OF	THER PASS THROUGH COSTS	S Provider Co		Period: From 01/01/2022 Fo 12/31/2022	Date/Time Pre 5/25/2023 5:4	pared: 9 pm
		Title	XVIII	Hospi tal	TEFRA	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	i		•			
30. 00 03000 ADULTS & PEDIATRICS	0	0	(	0	0	30.00
44.00 04400 SKILLED NURSING FACILITY	o	0		0		44.00
45. 00 04500 NURSING FACILITY	l ol	0		0		45.00
200.00 Total (lines 30 through 199)		0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
,		(sum of cols.	Days	5 ÷ col. 6)	Program Days	
		1 through 3,		,		
		minus col. 4)				
	4, 00	5. 00	6, 00	7, 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDIATRICS	0	0	19, 97	0.00	29	30.00
44.00 04400 SKILLED NURSING FACILITY		0	16, 13	0.00	0	44.00
45. 00 04500 NURSING FACILITY		0	7, 25		0	45.00
200.00 Total (lines 30 through 199)		0	43, 36			200.00
Cost Center Description	Inpatient	-	,	=1		
,	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
44.00 04400 SKILLED NURSING FACILITY	l ol					44. 00
45. 00 04500 NURSING FACILITY						45. 00
200.00 Total (lines 30 through 199)						200.00
	1					1

Health Financial Systems	CHILDRENS SPECIALIZ	ZED HOPSITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERVICE OTHER PASS	Provider CCN: 31-3300	Peri od:	Worksheet D
TUDOUCH COSTS			From 01/01/2022	Part IV

	H COSTS	RVICE UTHER PAS.	5 Provider C	UN. 31-3300	From 01/01/2022 To 12/31/2022	Part IV Date/Time Pre 5/25/2023 5:4	pared: 9 pm
			Title	XVIII	Hospi tal	TEFRA	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	_	-	1	_1	_	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0 11 00
	06000 LABORATORY	0	0		0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
	03550 MEDI CAL SERVI CES	0	0		0	0	76. 00
	03950 PSYCHI ATRI C	0	0		0	0	76. 01
	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	76. 98
	07699 LI THOTRI PSY	0	0		0	0	76. 99
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS	_	_	1			
	09000 CLINIC	0	0		0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
	04950 SCHOOL BASED PROGRAMS	0	0		0	0	93. 00
	09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0	0		0	0	
200.00	Total (lines 50 through 199)	0	1 0	1	0	0	200. 00

Health Financial Systems CHILDRENS SPECIALIZED HOPSITAL In Lieu of Form CMS-2552-10							
							2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provider	CCN: 31-3300	Peri od: From 01/01/2022	Worksheet D Part IV	
THROUG	H COSTS				To 12/31/2022		nared:
					10 12/31/2022	5/25/2023 5: 4	9 pm
			Ti tl	e XVIII	Hospi tal	TEFRA	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	·	Medi cal	(sum of cols	. Outpatient	(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
			·	and 4)		(see	
						instructions)	
		4.00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		0	0 88, 356	0.000000	54. 00
60.00	06000 LABORATORY	0		0	0 982, 614	0.000000	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0.000000	62. 30
65.00	06500 RESPI RATORY THERAPY	0		0	0 25, 583, 738	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0		0	0 17, 228, 956	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0		0	0 22, 123, 783	0.000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	0		o	0 25, 706, 894	0.000000	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		o	0 2, 495, 856	0.000000	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		o	0 3, 313, 042		73. 00
76.00	03550 MEDI CAL SERVI CES	0		o	0 281, 692	0.000000	76. 00
76. 01	03950 PSYCHI ATRI C	0		o	0 20, 609, 617	0.000000	76, 01
	07697 CARDI AC REHABI LI TATI ON	0		ol	0 0	0.000000	
	07698 HYPERBARI C OXYGEN THERAPY	0		ol	ol	0. 000000	
76. 99	07699 LI THOTRI PSY	0		ol	ol o	0.000000	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0		ő		0.000000	
00	OUTDATION CERVICE COCT CENTERS			<u>~ı</u>	<u></u>	2:00000	1 00

0 0 0

0.000000

0.000000

0.000000 0.000000

26, 165, 163

144, 579, 711

0

92.00 93. 00

93. 99

200.00

OUTPATIENT SERVICE COST CENTERS

92.00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART 93.00 | 04950 | SCHOOL BASED PROGRAMS | 93.99 | 09399 | PARTIAL HOSPITALIZATION PROGRAM | Total (lines 50 through 199)

90. 00 09000 CLI NI C

	HI LDRENS SPECI AL				eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provi der Co		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2022 To 12/31/2022		nanad.
				Γο 12/31/2022	Date/Time Prep 5/25/2023 5:49	pareu: 9 nm
		Title	XVIII	Hospi tal	TEFRA	7 piii
Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
3351 351161 35351 Pt 7511	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col . 6 ÷ col .	9	Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11. 00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0	(	2, 120	0	54.00
60. 00   06000   LABORATORY	0. 000000	2, 706		0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 000000	0		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	6, 482		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	5, 483		544	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	11, 225		0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0	0	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	2, 743		13, 500	0	73. 00
76. 00 03550 MEDI CAL SERVI CES	0. 000000	0		0	0	76. 00
76. 01 03950 PSYCHI ATRI C	0. 000000	0		0	0	76. 01
76. 97   07697   CARDIAC REHABILITATION	0. 000000	0		0	0	76. 97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0. 000000	0		0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0	0	76. 99
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
00 00 00000 CLINIC	0.000000	0		10 277	0	1 00 00

0. 000000

0. 000000 0. 000000 0. 000000 48, 277

0

0

28, 639

0 90.00

0 92.00 0 93.00 0 93.99 0 200.00

90. 00 | 09000 | CLINIC |
92. 00 | 09200 | OBSERVATION | BEDS | (NON-DISTINCT | PART |
93. 00 | 04950 | SCHOOL | BASED | PROGRAMS |
93. 99 | 09399 | PARTIAL | HOSPITALIZATION | PROGRAM |
200. 00 | Total (lines 50 through 199)

Health Financial Systems CF	HILDRENS SPECIA	LIZED HOPSITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2022 To 12/31/2022		narod:
				10 12/31/2022	5/25/2023 5: 4	
		Title	XVIII	Hospi tal	TEFRA	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		T	Г			
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 117547			0	249	
60. 00   06000   LABORATORY	0. 045199			0	0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0. 230242			0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 686162			0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 592182			0	322	67. 00
68. 00   06800   SPEECH PATHOLOGY	0. 540534	0		0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 529043			0	0	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1. 184852	13, 500		0	15, 996	73. 00
76. 00   03550   MEDI CAL   SERVI CES	21. 365580	0		0 0	0	76. 00
76. 01   03950   PSYCHI ATRI C	0. 664711	0		0 0	0	76. 01
76. 97   07697 CARDIAC REHABILITATION	0. 000000	0		0 0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	0. 562120	48, 277		0 598	27, 137	90. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0	0	92. 00
93.00 04950 SCHOOL BASED PROGRAMS	0. 000000	0		0 0	0	93. 00
93.99 09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0		0 0	0	93. 99
200.00 Subtotal (see instructions)		64, 441		0 598	43, 704	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201. 00
Only Charges						
202.00   Net Charges (line 200 - line 201)		64, 441		0 598	43, 704	202. 00

Health Financial Systems In Lieu of Form CMS-2552-10 CHILDRENS SPECIALIZED HOPSITAL APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 31-3300 Peri od: Worksheet D From 01/01/2022 To 12/31/2022 Part V Date/Time Prepared: 5/25/2023 5:49 pm Title XVIII Hospi tal TEFRA Costs Cost Center Description Cost Cost Reimbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 60.00 06000 LABORATORY 0 60.00 62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 06500 RESPIRATORY THERAPY 0 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00

0 0 0 0 0 0 0 0 0 0 0 0 06800 SPEECH PATHOLOGY 68.00 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 73.00 76. 00 03550 MEDICAL SERVICES 0 76 00 76.01 03950 PSYCHI ATRI C 0 76.01 76. 97 07697 CARDIAC REHABILITATION 0 76. 97 07698 HYPERBARI C OXYGEN THERAPY 76.98 0 76.98 76. 99 07699 LI THOTRI PSY 76. 99 0 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 0 0 0 0 336 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 0 93.00 04950 SCHOOL BASED PROGRAMS 0 93.00 93. 99 09399 PARTI AL HOSPI TALI ZATI ON PROGRAM 0 93.99 200.00 Subtotal (see instructions) 200. 00 336 201.00 Less PBP Clinic Lab. Services-Program 201. 00 Only Charges 202.00 Net Charges (line 200 - line 201) 336 202.00

Health Financial Systems C	HILDRENS SPECIA	ALIZED HOPSITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2022 To 12/31/2022		narod:
				10 12/31/2022	5/25/2023 5: 4	pareu. 9 pm
		Ti tl	e XIX	Hospi tal	TEFRA	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 227, 017	0	1, 227, 01	7 19, 973	61. 43	30.00
44.00 SKILLED NURSING FACILITY	738, 604		738, 60	4 16, 133	45. 78	44. 00
45.00 NURSING FACILITY	130, 113		130, 11	3 7, 256	17. 93	45. 00
200.00 Total (lines 30 through 199)	2, 095, 734		2, 095, 73	43, 362		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 989	122, 184				30.00
44.00   SKILLED NURSING FACILITY	15, 778	722, 317	'			44. 00
45.00 NURSING FACILITY	7, 096	127, 231				45. 00
200.00 Total (lines 30 through 199)	24, 863	971, 732	2			200. 00

Health Financial Systems	CHI LDRENS SPECIALI Z	ZED HOPSITAL		In Lieu of Form CMS-2552-10
ADDODEL ONMENT OF LADATIENT	ANGLILADY CEDVICE CADITAL COCTO	D	D!!	Wasslands at D

Health Financial Systems C	HILDRENS SPECIA	LIZED HOPSITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 5:4	
			e XIX	Hospi tal	TEFRA	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,			(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1	I	1		_	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	935				9	54. 00
60. 00   06000   LABORATORY	536	982, 614	1		23	60.00
62. 30   06250   BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000		0	62. 30
65. 00 06500 RESPI RATORY THERAPY	87, 107					
66. 00   06600   PHYSI CAL THERAPY	775, 546		1		-	
67. 00 06700 OCCUPATI ONAL THERAPY	711, 663				5, 092	
68. 00 06800 SPEECH PATHOLOGY	650, 373		1		11, 651	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	46, 042		1		1, 162	
73.00 07300 DRUGS CHARGED TO PATIENTS	79, 830					
76. 00   03550   MEDI CAL   SERVI CES	99, 412				0	76. 00
76. 01   03950   PSYCHI ATRI C	838, 362	20, 609, 617			219	
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	0.00000		0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000		0	76. 98
76. 99   07699   LI THOTRI PSY	0	0	0. 00000		0	76. 99
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.00000	00 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	699, 967	26, 165, 163	1		701	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.00000		0	92. 00
93. 00 04950 SCHOOL BASED PROGRAMS	476, 281	0	0.00000		0	93. 00
93. 99 09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0	0	0.00000		0	1 , 0 , , ,
200.00   Total (lines 50 through 199)	4, 466, 054	144, 579, 711	[	2, 280, 273	37, 023	200. 00

Health Financial Systems		LIZED HOPSITAL			u of Form CMS-	2552 - IU
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST	S Provider Co		Period: From 01/01/2022	Worksheet D Part III	
				To 12/31/2022		nared.
				10 12/01/2022	5/25/2023 5: 4	9 pm
		Ti tl	e XIX	Hospi tal	TEFRA	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2. 00	3. 00	
I NPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0	0		0	0	1 00.00
44.00  04400   SKILLED NURSING FACILITY	0	0		0		44.00
45. 00  04500   NURSING FACILITY	0	0		0		45. 00
200.00 Total (lines 30 through 199)	0	0		0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	I npati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
LABORT ENT DOUTLAND DEDIVING DOOT DENTEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			10.07	0.00	4 000	
30. 00   03000 ADULTS & PEDI ATRI CS	0	0	1			
44. 00 04400 SKILLED NURSING FACILITY		0	16, 13			
45. 00   04500   NURSING FACILITY		0	7, 25			
200.00 Total (lines 30 through 199)  Cost Center Description	1	0	43, 36	2	24, 863	200. 00
Cost Center Description	Inpatient Program					
	Pass-Through					
	Cost (col. 7 x					
	cost (cor. 7 x					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	7.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
44. 00   04400   SKI LLED   NURSI NG   FACI LI TY	0					44. 00
	1 9					
45. 00   04500   NURSING FACILITY	0					45.00

Health Financial Systems	CHILDRENS SPECIALIZ	ZED HOPSITAL	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIES	NT ANCILLARY SERVICE OTHER PASS	Provider CCN: 31-3300		Worksheet D
			From 01/01/2022	Dont IV

Part IV Date/Time Prepared: THROUGH COSTS From 01/01/2022 To 12/31/2022 5/25/2023 5:49 pm Title XIX Hospi tal TEFRA Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Program
Post-Stepdown Anestheti st Post-Stepdown Program Cost Adjustments Adjustments 1.00 2.00 ЗА 3.00 2A ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 0 54.00 06000 LABORATORY 60.00 0 60.00 0 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 65.00 06500 RESPIRATORY THERAPY 0 0 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 0 66.00 0 06700 OCCUPATI ONAL THERAPY 67.00 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 01 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 73.00 03550 MEDICAL SERVICES 0 76.00 76.00 0 76. 01 03950 PSYCHI ATRI C 76.01 07697 CARDIAC REHABILITATION 0 0 76. 97 76. 97 0 0 07698 HYPERBARI C OXYGEN THERAPY 76. 98 76. 98 0 0 76.99 07699 LI THOTRI PSY 0 0 76. 99 07700 ALLOGENEIC STEM CELL ACQUISITION
OUTPATIENT SERVICE COST CENTERS 77. 00 0 0 0 0 0 77.00 90.00 90.00 09000 CLI NI C 0 0 0 0 0 0 0 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 93. 00 04950 SCHOOL BASED PROGRAMS 0 93.00 0 0 0 93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM 0 o 93. 99 200.00 Total (lines 50 through 199) 0 200. 00

Haalah Firanaial Costana	CHILL DDENG CDECLALL	IZED HODGITAL		1 1:-	£ F OMC 3	NEED 10
Health Financial Systems	CHI LDRENS SPECI ALI				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCII	LLARY SERVICE OTHER PASS	Provider CO	CN: 31-3300	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2022	Part IV	
1111100011 00010				To 12/31/2022	Date/Time Pre	pared:
					5/25/2023 5: 4	9 pm
		Ti tl	e XIX	Hospi tal	TEFRA	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medical (	sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost 1	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	

						3/23/2023 3.4	7 PIII
			Ti tl	e XIX	Hospi tal	TEFRA	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost	1, 2, 3, and	,		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	(		88, 356		
60.00	06000 LABORATORY	0	(	) (	982, 614		1
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	(	) (	0	0. 000000	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	(	) (	25, 583, 738		
66. 00	06600 PHYSI CAL THERAPY	0	(	) (	17, 228, 956		l
67. 00	06700 OCCUPATI ONAL THERAPY	0	(	) (	22, 123, 783	0.000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	(	) (	25, 706, 894	0.000000	68. 00
71. 00		0	(	) (	2, 495, 856	0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	(	) (	3, 313, 042	0.000000	73. 00
76.00	03550 MEDI CAL SERVI CES	0	(	) (	281, 692	0.000000	76. 00
76. 01	03950 PSYCHI ATRI C	0	(	) (	20, 609, 617	0.000000	76. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	(	) (	0	0.000000	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	(	) (	0	0.000000	76. 98
76. 99	07699 LI THOTRI PSY	0	(	) (	0	0.000000	76. 99
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	(	) (	0	0.000000	77. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00		0	(	) (	26, 165, 163	0.000000	90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	(	) (	0	0.000000	92. 00
93. 00	04950 SCHOOL BASED PROGRAMS	0	(	) (	0	0.000000	93. 00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	(	) (	0	0.000000	93. 99
200.00	Total (lines 50 through 199)	0	(	) (	144, 579, 711		200. 00

Health Financial Systems	CHI LDRENS SPECI ALI	ZED HOPSITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCI THROUGH COSTS	LLARY SERVICE OTHER PASS	Provider CO	CN: 31-3300	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prep 5/25/2023 5:4	
		Ti tl	e XIX	Hospi tal	TEFRA	
Cost Center Description	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program	Outpatient Program	Outpati ent	

			'`	7270172022	5/25/2023 5: 4	
		Ti tl	e XIX	Hospi tal	TEFRA	
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	866		0	0	54.00
60. 00  06000   LABORATORY	0. 000000	41, 733	0	0	0	60. 00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	0	0	0	62. 30
65. 00  06500  RESPI RATORY THERAPY	0. 000000	1, 055, 546	0	0	0	65. 00
66. 00  06600 PHYSI CAL THERAPY	0. 000000	156, 730	0	0	0	66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0. 000000	158, 287	0	0	0	67. 00
68.00   06800   SPEECH PATHOLOGY	0. 000000	460, 517	0	0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	63, 018	0	0	0	71. 00
73.00   07300   DRUGS CHARGED TO PATIENTS	0. 000000	311, 973	0	0	0	73. 00
76. 00   03550   MEDI CAL   SERVI CES	0. 000000	0	0	0	0	76. 00
76. 01  03950  PSYCHI ATRI C	0. 000000	5, 381	0	0	0	76. 01
76. 97   07697   CARDIAC REHABILITATION	0. 000000	0	0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	0	0	0	76. 98
76. 99   07699 LI THOTRI PSY	0. 000000	0	0	0	0	76. 99
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	26, 222	0	0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	0	0	0	92.00
93.00 04950 SCHOOL BASED PROGRAMS	0. 000000	0	0	0	0	93.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000	0	0	o	0	93. 99
200.00 Total (lines 50 through 199)		2, 280, 273	0	0	0	200. 00

Health Financial Systems CF	HILDRENS SPECIA	ALIZED HOPSITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co	<u> </u>	Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 5:4	
		Titl	e XIX	Hospi tal	TEFRA	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 117547		)	0	0	1 0 11 00
60. 00   06000   LABORATORY	0. 045199		)	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	1	)	0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0. 230242		)	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 686162	. 0	29, 53	8 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 592182	. 0	25, 050	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 540534	. 0	23, 35	7 0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 529043	0	)	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1. 184852	. 0	478	8 0	0	73. 00
76. 00 03550 MEDI CAL SERVI CES	21. 365580	0	)	0	0	76. 00
76. 01   03950   PSYCHI ATRI C	0. 664711	0	5, 454, 58	8 0	0	76. 01
76. 97 07697 CARDIAC REHABILITATION	0. 000000	0	)	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	)	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0	)	0	0	76. 99
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	)	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 562120	0	1, 521, 59	5 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	)	0	0	92.00
93.00 04950 SCHOOL BASED PROGRAMS	0. 000000	0	)	0	0	93. 00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000	0	)	0	0	93. 99
200.00 Subtotal (see instructions)		0	7, 054, 60	6 0	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0		201.00
Only Charges						
202.00   Net Charges (line 200 - line 201)		0	7, 054, 60	6 0	0	202. 00

Provider CCN: 31-3300

			Т	o 12/31/2022	Date/Time Prepared 5/25/2023 5:49 pm	d:
		Ti tl	e XIX	Hospi tal	TEFRA	_
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	)		54. 0	
60. 00   06000   LABORATORY	0	0	)		60.0	
62.30   06250   BLOOD CLOTTING FOR HEMOPHILIACS	0	0	)		62. 3	
65. 00   06500   RESPI RATORY THERAPY	0	0	)		65. (	
66. 00   06600   PHYSI CAL THERAPY	20, 268	0			66. 0	00
67. 00  06700 OCCUPATI ONAL THERAPY	14, 834	0			67. (	00
68. 00 06800 SPEECH PATHOLOGY	12, 625	0			68. (	00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			71. (	00
73.00 07300 DRUGS CHARGED TO PATIENTS	566	0			73. (	00
76. 00   03550   MEDI CAL   SERVI CES	0	0			76. (	00
76. 01   03950   PSYCHI ATRI C	3, 625, 725	0			76. (	01
76. 97 07697 CARDIAC REHABILITATION	0	0			76. 9	97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	)		76. 9	98
76. 99 07699 LI THOTRI PSY	0	0	)		76. 9	99
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	)		77. (	00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	855, 319	0			90. (	00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	)		92. (	00
93. 00 04950 SCHOOL BASED PROGRAMS	0	0	1		93. (	00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	)		93. 9	99
200.00 Subtotal (see instructions)	4, 529, 337	0			200. (	00
201.00 Less PBP Clinic Lab. Services-Program	0				201. (	00
Only Charges						
202.00 Net Charges (line 200 - line 201)	4, 529, 337	0			202. (	00
	•	•	•		•	

Health Financial Systems	CHILDRENS SPECIALIZED HOPSITAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 31-3	300 Peri od: From 01/01/2022	Worksheet D-1	
		To 12/31/2022		pared: 9 pm
	Title XVIII	Hospi tal	TEFRA	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
I NPATI ENT DAYS				

Dect   ALL PROFIDER COMPONENTS			Title XVIII	Hospi tal	TEFRA	, piii
INPARTENT MAYS   1.00   Impatient days (including private room days and seing-bed days, excluding newborm)   19, 973   2.00   Impatient days (including private room days, secluding seing-bed and moderate room days, 0.3   3.00   Private room days (coulding seing-bed and observation bed days)   17 you have only private room days, 0.3   3.00   Private room days (excluding seing-bed and observation bed days)   17 you have only private room days, 0.3   3.00   3.0		Cost Center Description			1. 00	
Impatient days (Including private room days and swing-bed days, excluding newborn)   19,973   2.00						
Inpatient days (including private room days, excluding swing-bed and nesborn days)   19,773   2,00	1 00		excluding newborn)		19 973	1 00
do not complete this line.  4. OS Sell-private room days (excluding swing-bed and observation bed days)  1. Total swing-bed SM type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. OD Total swing-bed SM type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. OD Total swing-bed MF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8. OD Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. OD Total Inpatient days including private room days after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  10. OS sing-bed SMF type inpatient days applicable to title XVIII only (including private room days)  11. OS sing-bed SMF type inpatient days applicable to title XVIII only (including private room days)  12. OS sing-bed SMF type inpatient days applicable to title XVIII only (including private room days)  13. OS sing-bed SMF type inpatient days applicable to title XVIII only (including private room days)  14. OS SMR bed NF type inpatient days applicable to title XVIII only (including private room days)  15. OS SMR bed NF type inpatient days applicable to title XVIII only (including private room days)  16. OS Name bed NF type inpatient days applicable to title XVIII only (including private room days)  17. OS Medicare rate for swing-bed SMF services applicable to services after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  18. ON Including the XVIII only (including private room days)  19. ON Medicare rate for swing-bed SMF services applicable to services after December 31 of the cost reporting period (including private room days)  19. ON Medicare rate for swing-bed SMF services applicable to						
5.00 Total swing-bed SRF type inpatient days (including private room days) through December 31 of the cost reporting period of swing-bed SRF type inpatient days (including private room days) after December 31 of the cost reporting period of the cos	3. 00	Private room days (excluding swing-bed and observation bed day		vate room days,	0	3. 00
Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)	4.00	·	ed days)		19, 973	4. 00
10tal 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)   7.00   7	5. 00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost		5. 00
Total saving-bed NF type inpatient days (including private room days) after December 31 of the cost   0   7.00	6. 00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3°	of the cost	0	6. 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost period (if cal endary seyer, enter 0 on this line)   Popular of the inpatient days including private room days applicable to the Program (excluding swing-bed and period newborn days) (see instructions)   Popular of the cost instructions of the cost reporting period (see instructions)   Popular of the cost   Popu	7. 00		n days) through December 3	31 of the cost	0	7. 00
10.00   Swings-bed SNF type inpatient days applicable to title XVIII only (including private room days)   0.00	8. 00	Total swing-bed NF type inpatient days (including private roor	n days) after December 31	of the cost	0	8. 00
10.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)   10.00   10.00   11.00   11.00   12.	9. 00	Total inpatient days including private room days applicable to	the Program (excluding s	swing-bed and	29	9. 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) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 16.00 Nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 19.00 Nursery days (tit	10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		om days)	0	10. 00
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period necessary private room days applicable to services after December 31 of the cost reporting period necessary private room days applicable to services after December 31 of the cost reporting period necessary private room days applicable to services after December 31 of the cost reporting period necessary private room days applicable to services after December 31 of the cost reporting period (line 5 x line 17) 20.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18) 21.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 29) 22.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 29) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 29) 24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 29) 25.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 29) 26.00 Total swing-bed cost (see instructions) 27.00 Gener	11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private roo	om days) after	0	11. 00
13.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days)   0   13.00	12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		room days)	0	12. 00
14.00   Modically necessary private room 'days applicable to the Program (excluding swing-bed days)   0   14.00   15.00   16.00   Nursery days (title V or XIX only)   0   15.00   15.00   Nursery days (title V or XIX only)   0   15.00   15.00   Nursery days (title V or XIX only)   0   15.00	13. 00		only (including private	room days)	0	13. 00
15.00   Total nursery days (title V or XIX only)	14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ear, enter O on this line) am (excluding swing-bed da	ays)	0	14. 00
SW NG BED ADJUSTNENT  17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost (19.00 periting period (19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost (19.00 periting period (19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost (19.00 periting period (19.00 periting periting periting (19.00 periting periting periting periting periting (19.00 periting periting periting periting periting (19.00 periting		Total nursery days (title V or XIX only)			-	
17.00   Nedicare rate for swing-bed SNF services applicable to services through December 31 of the cost periting period   18.00   18.00   18.00   18.00   18.00   18.00   18.00   19	16. 00				0	16. 00
18.00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period   19.00   19.	17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
19.00   Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20.00   20	18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of th	ne cost	0. 00	18. 00
20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27.00 General inpatient routine service cast net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  34.00 Average per diem private room charge differential (line 34 x line 31)  35.00 Average per diem private room charge differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  38.00 Program general inpatient routine service cost (line 9 x line 38)  39.00 Program general inpatient routine service cost (line 9 x line 38)  30.00 Program general inpatient routine service cost (line 9 x line 38)  30.00 Program general in	19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of t	the cost	0. 00	19. 00
21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 19)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 Semi-private room charges (excluding swing-bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 + line 3)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average per ivate room per diem charge (line 29 + line 3)  33.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  36.00 Private room cost differential (line 3 x line 31)  37.00 General inpatient routine service cost net of swing-bed charges)  38.00 Adverage per diem private room cost differential (line 34 x line 31)  37.00 Fivate room cost differential (line 3 x line 35)  38.00 Adjusted general inpatient routine service cost net of swing-bed cost and private room cost differential (line 32 minus line 36)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  40 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40 Medically necessary private room cost applicable to the Program (line 14 x line 35)	20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of the	e cost	0. 00	20. 00
5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 v line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 v line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 General inpatient routine service charges (excluding swing-bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 29 + line 3)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 35, 053, 117)  27 minus line 36)  28.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		Total general inpatient routine service cost (see instructions			35, 053, 117	
x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  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) 35,053,117  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00  29.00 Private room charges (excluding swing-bed charges) 0 29.00  31.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00  31.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.000000  32.00 Average private room per diem charge (line 29 + line 3) 0.00  33.00 Average per diem private room charge (line 30 + line 4) 0.00  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0.00  35.00 Average per diem private room cost differential (line 3 x line 31) 0.00  36.00 Private room cost differential adjustment (line 3 x line 35) 0.00  27 minus line 36) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00		er 31 of the cost reportin	ng period (line	0	22. 00
7 x line 19)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 vine 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average private room per diem charge (line 29 ÷ line 3)  33. 00 Average semi-private room per diem charge (line 29 ÷ line 3)  34. 00 Average semi-private room cost differential (line 32 minus line 33)(see instructions)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 35,053,117)  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost per diem (see instructions)  50. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  50. 00 40. 00	23. 00		31 of the cost reporting	period (line 6	0	23. 00
x line 20)  26. 00  Total swing-bed cost (see instructions)  Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00  29. 00  Private room charges (excluding swing-bed and observation bed charges)  30. 00  Semi-private room charges (excluding swing-bed charges)  30. 00  Semi-private room charges (excluding swing-bed charges)  30. 00  31. 00  General inpatient routine service cost/charge ratio (line 27 + line 28)  32. 00  Average private room per diem charge (line 29 + line 3)  33. 00  Average semi-private room per diem charge (line 30 + line 4)  34. 00  Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35. 00  Average per diem private room cost differential (line 34 x line 31)  Drivate room cost differential adjustment (line 3 x line 35)  Trivate room cost differential adjustment (line 3 x line 35)  Trivate room cost differential adjustment (line 3 x line 35)  Average neral inpatient routine service cost net of swing-bed cost and private room cost differential (line 35, 053, 117)  Bas. 00  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)	24. 00		ີ 31 of the cost reportino	g period (line	0	24. 00
26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28. 00 Frivate room charges (excluding swing-bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30. 00 Average private room per diem charge (line 29 + line 3)  30. 00 Average semi-private room per diem charge (line 30 + line 4)  30. 00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  30. 00 Average per diem private room cost differential (line 34 x line 31)  30. 00 Average per diem private room cost differential (line 34 x line 31)  30. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 35, 053, 117)  30. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 35, 053, 117)  30. 00 General inpatient routine service cost per diem (see instructions)  30. 00 Program general inpatient routine service cost (line 9 x line 38)  30. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  30. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	25. 00	] 3	31 of the cost reporting p	period (line 8	0	25. 00
28. 00 29. 00 29. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 31. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 31. 00 32. 00 33. 00 34. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 39. 00 30. 00 3		, ,	(line 21 minus line 26)			
29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 35, 053, 117)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 29.00  30.00  30.00  30.00  30.00  31.00  32.00  32.00  34.00  35.00  36.00  37.00  36.00  37.00  37.00		PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	,			
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average semi-private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Average per diem private room cost differential (line 34 x line 31) 37.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 35, 053, 117)  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0.000000000000000000000000000000000		,	d and observation bed char	rges)	-	
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33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 35,053,117)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			- line 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 35, 053, 117)  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 34.00  35.00 35.00  36.00  37.00  38.00  39.00  40.00	32.00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	32. 00
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 35, 053, 117)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 755.03 38.00  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	33.00				0.00	
36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 35,053,117 and 37.00 part 11 - HOSPITAL AND SUBPROVIDERS ONLY program inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  36.00 35,053,117 and 37.00 and 37.0	34.00			ons)	0.00	34.00
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27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,755.03 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,755.03  38.00  Program general inpatient routine service cost (line 9 x line 38)  50,896  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37. 00	27 minus line 36)			37. 00	
Adjusted general inpatient routine service cost per diem (see instructions)  1,755.03  38.00  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  1,755.03  38.00  39.00  40.00						
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 50,896 39.00 40.00	38 NO				1 755 03	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
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	41.00	, , , , , , , , , , , , , , , , , , , ,				

Total   Total   Total   Total   Average Per	Heal th	Financial Systems CF	HILDRENS SPECIA	LIZED HOPSITAL	_	In Lie	eu of Form CMS-	2552-10
Title Will   Respite   Title						Period: From 01/01/2022	Worksheet D-1 Date/Time Pre	pared:
Total   Average Por   Program Roys   Program Roys   Program Roys   Program Roys   Repair Roys   Re				Ti tl e	2 XVIII	Hospi tal		9 pm
200   NUMBER (**CHITE V 8. FIX only)   1.00   2.00   3.00   4.00   5.00   4.0		Cost Center Description	Total					
1.00   2.00   3.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   6.00		·	Inpatient Cost	Inpatient Days		÷		
			1 00	2.00		4.00		
Internst via Care Type Input ient Hospit full Units	42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
44.00   CORDINARY CARE UNIT								1
45.00   SURIC LINTENSIVE CARE UNIT   46.00								1
40.00   SURCICAL INTERSIVE CARE UNIT   44.00								1
47.00   OTHER SPECIAL CARE (SPECIFY)   47.00								1
1.00								1
		Cost Center Description					1.00	
Program inpati ent cell ular interrupt acquisition cost (Worksheet D-6, Part III, Iine 10, column 1)	48.00	Program inpatient ancillary service cost (Wks	st D_3 col 3	line 200)				48.00
PASS_THROUGH_COST_AD_UISTMENTS   50.00   Pass through costs applicable to Program inpatient routine services (from Wkst. D., sum of Parts I and   1,781   50.00   51.00   Pass through costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts II and   1,781   50.00   51.00   70.00					III, line 10,	column 1)		1
50.00   Pass through costs applicable to Program Inpatient routine services (from Wkst. D. sum of Parts II and II)   51.00   71.00   71.00   72.00	49. 00	Total Program inpatient costs (sum of lines					68, 030	49. 00
111   110	FO 00				- WI+ D	E Dt-  l	I 4 701	 
51.00   Pass through costs applicable to Program Inpatient and Illary services (From Wkst. 0, sum of Parts II   2,000   52.00   Total Program excludable cost (sum of lines 50 and 51)   2,600   52.00   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)   25.00   Region   25.00   Regio	50.00		atrent routine	services (Tron	n wkst. D, Sun	n or Parts I and	1, /81	50.00
Total Program excludable cost (sun of lines 50 and 51)   3.00   Total Program injent operating cost excluding capital related, non-physician anesthetist, and   65,430   53.00   74   75   75   75   75   75   75   75	51. 00		atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	819	51. 00
Solid   Program inpatient operating cost excluding capital related, non-physician anesthetist, and   65,430   \$3.00		1						
medical education costs (line 49 minus line 52)   TARKET AMOUNT AMD LIMIT COMPITATION   2   54.00				lated non-nhy	sician anesth	netist and		
54.00   Program discharges   2   54.00   55.01   Permanent adjustment amount per discharge   45.718.03   55.00   Solid Permanent adjustment amount per discharge   45.50   55.00   Permanent adjustment amount per discharge (contractor use only)   0.00   55.02   55.02   55.02   55.00   Target amount (line 54 x Sum of lines 55 , 55.01, and 55.02   56.00   70	33. 00			rated, non prij	ysi ci air anesti	ictist, and	03, 430	33.00
55.02   Adjustment amount per discharge   0.00   55.02     55.02   Adjustment amount per discharge (contractor use only)   0.00   55.02     55.02   Adjustment amount per discharge (contractor use only)   0.00   55.02     55.02   Adjustment amount per discharge (contractor use only)   0.00   55.02     57.00   Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)   0.60   55.02     57.00   Borus payment (see instructions)   1.829   58.00     58.00   Borus payment (see instructions)   1.829   58.00     59.00   Total cost (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   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     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)   0.00   60.00     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)   0.00   60.00     55.00   All lowable Inpatient costs plus incentive payment (see instructions)   0.00   60.00     56.00   All lowable Inpatient cost plus incentive payment (see instructions)   0.00   60.00     56.00   All core sing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)   0.00   60.00     56.00   Contractions   0.00   60.00								1
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CAH, see instructions  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)  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)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  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)  71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital -related costs (line 9 x line 76)  77.00 Program capital -related costs (line 9 x line 77)  78.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79)  80.00 Total Program routine service cost limitation  18.00 Inpatient routine service cost limitation  18.00 Reasonable inpatient routine service costs (see instructions)	// 00		+- (1:	// -l   ! /	· F.	l!\		// 00
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26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  83.00 Reasonable inpatient routine service costs (see instructions)  83.00								1
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79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  83.00 Reasonable inpatient routine service costs (see instructions)  79.00  80.00  81.00  81.00  82.00								1
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Health Financial Systems C	HILDRENS SPECIALIZED HOPSITAL			In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1		
				From 01/01/2022 To 12/31/2022			
		Title	XVIII	Hospi tal	TEFRA		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2. 00	3.00	4. 00	5. 00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00 Capital -related cost	1, 227, 017	35, 053, 117	0. 03500	5 0	0	90. 00	
91.00 Nursing Program cost	0	35, 053, 117	0.00000	0 0	0	91.00	
92.00 Allied health cost	0	35, 053, 117	0.00000	0	0	92. 00	
93.00 All other Medical Education	0	35, 053, 117	0. 00000	0 0	0	93. 00	

Health Financial Systems	CHILDRENS SPECIALIZED HOPSITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 31-3300	Peri od: From 01/01/2022	Worksheet D-1
	Component CCN: 31-5239		
	Title XVIII	Skilled Nursing	PPS

Descripting period (an external period) and set ing-bed days, excluding newborn) (an external days) (including private room days, excluding seting-bed days, excluding newborn) (an external days) (including private room days, excluding seting-bed and observation bed days). (but the control days) (and the control days) (a			Title XVIII	Skilled Nursing Facility	PPS	
		Cost Center Description			1 00	
Impatient days (including private room days and swing-bed days, excluding newborn)   10.133   1.00					1.00	
1.0   1.0	1 00				1/ 122	1 00
Drivate room days; (excluding swing-bed and observation bed days). If you have only private room days.  do not complete this is line.  5.00 Following and swing-bed SWF type inpatient days; (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.00 Following period (if calendar year, enter 0 on this line)  7.01 Following period (if calendar year, enter 0 on this line)  7.02 Following period (if calendar year, enter 0 on this line)  7.03 Following period (if calendar year, enter 0 on this line)  7.04 Following period (if calendar year, enter 0 on this line)  7.05 Following period (if calendar year, enter 0 on this line)  7.06 Following period (if calendar year, enter 0 on this line)  7.07 Following period (if calendar year, enter 0 on this line)  8.08 Following period (if calendar year, enter 0 on this line)  8.09 Following period (if calendar year, enter 0 on this line)  8.00 Following period (if calendar year, enter 0 on this line)  8.01 Following period (if calendar year, enter 0 on this line)  8.02 Following December 31 of the cost reporting period (see instructions)  8.03 Following December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8.04 Following December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8.05 Following December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8.06 Following December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9.07 Following December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9.07 Following December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9.08 Following December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9.09 Following December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9.00 Following December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9.00 Follo						
Semi-private room days (excluding swing-bed and observation bed days)   16,133   4.00   5.00   Total swing-bed SFF type Inpatient days (including private room days) after December 31 of the cost		Private room days (excluding swing-bed and observation bed day		ivate room days,		
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (If callendar year, enter 0 on this line)   Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (If callendar year, enter 0 on this line)   Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (If callendar year, enter 0 on this line)   Total inpatient days swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (If callendar year, enter 0 on this line)   Total inpatient days including private room days) after December 31 of the cost reporting period (If callendar year, enter 0 on this line)   Total inpatient days including private room days)   Total swing-bed SNF type inpatient days (including private room days)   Total swing-bed SNF type inpatient days applicable to the swing-bed SNF type inpatient days applicable to the swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days)   Total SNF type inpatient days applicable to titles V or XIX only (including private room days)   Total SNF type inpatient days applicable to titles V or XIX only (including private room days)   Total Increase SNF type inpatient days applicable to titles V or XIX only (including private room days)   Total Increase SNF type inpatient days applicable to titles V or XIX only (including private room days)   Total Increase SNF type inpatient days applicable to the Program (excluding swing-bed days)   Total SNF type inpatient days applicable to services after December 31 of the cost   Total SNF type services applicable to services after December 31 of the cost   Total SNF type services applicable to services after December 31 of the cost   Total SNF type services after December 31 of the cost reporting period (line   Total SNF type services through December 31 of the cost reporting period (line   Total	4 00				1/ 122	4 00
reporting period.  6. 00 Total swing-bed SM type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  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)  10. 01 Swing-bed SMF type inpatient days (and in this line)  10. 02 Swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  11. 02 Swing-bed SMF type inpatient days applicable to the Program (excluding private room days) after December 31 of the cost reporting period (see instructions)  11. 03 Swing-bed SMF type inpatient days applicable to title SWF (including private room days) after December 31 of the cost reporting period (see instructions)  12. 00 Swing-bed SMF type inpatient days applicable to titles Vor XIX only (including private room days) after December 31 of the cost reporting period (see instructions)  13. 00 Swing-bed SMF type inpatient days applicable to titles Vor XIX only (including private room days)  14. 00 Swing-bed NF type inpatient days applicable to titles Vor XIX only (including private room days)  15. 00 Swing-bed NF type inpatient days applicable to titles Vor XIX only (including private room days)  16. 00 Midclid in necessary private room days applicable to titles Vor XIX only (including private room days)  17. 00 Midclid in necessary private room days applicable to services through December 31 of the cost properting period (including private room days)  18. 00 Midclid in necessary private room days applicable to services through December 31 of the cost properting period (including private room days)  18. 00 Midclid in necessary private room days applicable to services after December 31 of the cost properting period (inc				r 31 of the cost		
reporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed Nr type inpatient days (including private room days) through December 31 of the cost proporting period (if calendar year, enter 0 on this line)  8. 00 Total swing-bed Nr type inpatient days (including private room days) after December 31 of the cost proporting period (if calendar year, enter 0 on this line)  10. 00 Swing-bed SNR type inpatient days applicable to the Program (excluding swing-bed and newbord adys) (see Instructions)  11. 00 Swing-bed SNR 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)  12. 00 Swing-bed NR 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)  13. 00 Swing-bed NR type inpatient days applicable to titles V or XIX only (including private room days)  14. 00 Modically inacessary private room days applicable to the Program (excluding swing-bed days)  15. 00 Total nursery days (title V or XIX only)  16. 00 Modicard year, enter 0 on this line)  17. 00 Modicard year, enter 0 on this line)  18. 00 Modicard year, enter 0 on this line)  18. 00 Modicard years wing-bed SNF services applicable to services through December 31 of the cost  18. 00 Modicard rate for swing-bed SNF services applicable to services after December 31 of the cost  18. 00 Modicard rate for swing-bed SNF services applicable to services after December 31 of the cost  18. 00 Modicard rate for swing-bed SNF services applicable to services after December 31 of the cost  18. 00 Modicard rate for swing-bed NF services applicable to services after December 31 of the cost  18. 00 Modicard rate for swing-bed NF services applicable to services after December 31 of the cost  18. 00 Modicard rate for swing-bed NF services after December 31 of the cost reporting period (line 8 x line 12)  28. 00 Modicard rate for swing-bed w		reporting period	3 ,			
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost   0	6. 00		om days) after December	31 of the cost	0	6.00
1.00   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost   0   8.00	7. 00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line)  7. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  8. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) swing-bed NF type inpatient days applicable to title XVIII only (including private room days) of through December 31 of the cost reporting period (see instructions) of through December 31 of the cost reporting period (see instructions) of through December 31 of the cost reporting period (see instructions) of the cost reporting period (see instructions) of the cost reporting period (including private room days) of the cost reporting period (including private room days) of the cost reporting period (including private room days) of the cost reporting period (including private room days) of the cost reporting period (including private room days) of the cost reporting period (including private room days) of the cost reporting period (including private room days) of the cost reporting period (see instructions)	8. 00	, , , , , , , , , , , , , , , , , , , ,	m davs) after December 3	1 of the cost	0	8. 00
newborn days)   (see instructions)   0   10   00   00   00   00   00   00		reporting period (if calendar year, enter 0 on this line)	-			
10.00 Swing-bad SNF type inpatient days applicable to title XVIII only (including private room days) after brown becember 31 of the cost reporting period (see instructions) after 0 December 31 of the cost reporting period (see instructions) 12.00 Swing-bad SNF type inpatient days applicable to title XVIII only (including private room days) after 0 December 31 of the cost reporting period (incleandar year, enter 0 on this line) 12.00 Swing-bad NF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bad NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bad days) 0 15.00 Total nursery days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 15.00 Nursery days (title V or XIX only) 0 15.00 Nursery days (title V or XIX only) 0 15.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 0.00 17.00 Nursery days (title V or XiX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 0.00 17.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX on	9. 00		o the Program (excluding	swing-bed and	0	9. 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 calendary year, enter 0 on this Ilne)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days)  14.00 Medically necessary private room days applicable to titles V or XIX only (Including private room days)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  16.00 Nursery days (title V or XIX only)  17.00 Nursery days (title V or XIX only)  18.00 SMIN BED ADUSTMEN  18.00 Applicable SNF services applicable to services through December 31 of the cost reporting period or swing-bed SNF services applicable to services after December 31 of the cost  19.00 Medical drate for swing-bed NF services applicable to services through December 31 of the cost  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 x Ilne 17)  20.01 Medical drate for swing-bed NF services after December 31 of the cost reporting period (line 6 x Ilne 18)  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x Ilne 18)  23.0	10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days)	o	10. 00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)	11 00			nom days) after	0	11 00
through December 31 of the cost reporting period  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Noursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost  18.00 Noursery days (title V or XIX only)  18.00 Noursery days (title V or XIX only)  19.00 Noursery days (title Vor XIX only)  19.00 Noursery days (title Vor XIX only)  19.00 Noursery days (title Vor XIX only)  19.00 Nours	11.00	December 31 of the cost reporting period (if calendar year, el	nter 0 on this line)	dom days) arter		11.00
13.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   13.00   13.00   after December 31 of the cost reporting period (if callendar year, enter 0 on this line)   0   15.00   15.00   15.00   16.00   17.00   16.00   18.00   1	12. 00	Swing-bed NF type inpatient days applicable to titles V or XII	X only (including privat	e room days)	0	12. 00
14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   0   15.00   0   0   0   0   0   0   0   0   0	13. 00		X only (including privat	e room days)	0	13. 00
15.00   Total nursery days (title V or XIX only)   0   16.00	14.00					14.00
16. 00   Nursery days (title V or XIX only)   16. 00   16. 00   17. 00   17. 00   18. 00			am (excluding swing-bed	days)		
17. 00   Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost   0.00   17. 00   18. 00   18. 00   19.		Nursery days (title V or XIX only)			0	
reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost cost (are reporting period period lead of a rate for swing-bed NF services applicable to services after December 31 of the cost cost (are instructions)  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost cost (are instructions)  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 Total swing-bed cost (see instructions)  29.00 PRIVATE ROUM DIFFERENTIAL ADJUSTMENT  29.00 Semi-private room charges (excluding swing-bed charges)  29.00 Average perivate room per diem charge (line 30 ± line 4)  20.00 Average perivate room per diem charge (line 30 ± line 4)  20.00 Average perivate room charge differential (line 32 minus line 33) (see instructions)  20.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  20.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  20.00 Average per diem private room cost differential (line 34 x line 31)  20.00 Average per diem private room cost differential (line 34 x line 31)  20.00 Average per diem private room cost differential (line 36)  20.00 Average per diem private room cost differential	17 00		es through December 31 c	f the cost	0.00	17 00
reporting period  Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  10.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost cost of reporting period  10.00 Total general inpatient routine service cost (see instructions)  10.00 Total general inpatient routine service safter December 31 of the cost reporting period (line 5 x line 17)  10.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18)  10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)  10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)  10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)  10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19)  10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  10.01 Total swing-bed cost (see instructions)  10.01 Total swing-bed cost (see instructions)  10.01 Total swing-bed cost (see instructions)  10.02 Total swing-bed cost (see instructions)  10.03 Total swing-bed cost (see instructions)  10.04 Total swing-bed cost (see instructions)  10.05 Semi-private room charges (excluding swing-bed charges)  10.06 Semi-private room charges (excluding swing-bed charges)  10.07 Semi-private room charges (excluding swing-bed charges)  10.00 Semi-private room charges (excluding swing-bed charges)  10.00 Average per diem private room cost differential (line 27 + line 28)  10.00 Average per diem private room cost differential (line 30 + line 4)  10.00 Average per diem private room cost differential (line 3 x line 31)  10.00 General inpatient routine service cost per diem (see instructions)  10.00 General inpatient routine service cost per diem (se		reporting period	ű			
9. 00 dedical d rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (20. 00 period period period (30. 00 period period period period period period period (30. 00 period (30. 00 period (11 period p	18. 00		es after December 31 of	the cost	0. 00	18. 00
Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period   16,897,044   21.00   20.00	19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
21.00   Total general inpatient routine service cost (see instructions)   16,897,044   21.00   22.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 17)   23.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)   24.00   X line 18)   24.00   Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)   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)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   26.00   26.00   27.00   26.00   27.00   26.00   27.00   26.00   27	20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0. 00	20. 00
5 x line 17)  23.00	21. 00		s)		16, 897, 044	21. 00
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7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 vine 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ± line 28)  30.00 Average private room per diem charge (line 29 ± line 3)  30.00 Average semi-private room per diem charge (line 29 ± line 4)  31.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  32.00 Average per diem private room cost differential (line 34 x line 31)  33.00 Average per diem private room cost differential (line 34 x line 31)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 16, 897, 044)  37.00 Adjusted general inpatient routine service cost line 9 x line 38)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00	24 00		r 31 of the cost reporti	ng period (line	0	24 00
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PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Pri vate room charges (excluding swing-bed charges)  30.00 Semi-pri vate room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average pri vate room per diem charge (line 29 ÷ line 3)  32.00 Average semi-pri vate room per diem charge (line 30 ÷ line 4)  33.00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions)  34.00 Average per diem pri vate room cost differential (line 34 x line 31)  35.00 Average per diem pri vate room cost differential (line 34 x line 31)  36.00 Pri vate room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 16,897,044)  37.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00		,			- 1	
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35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 16, 897, 044)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 35.00  16,897,044  37.00  38.00  39.00  40.00			nus line 33)(see instruc	tions)		•
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PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00	37. 00		and private room cost di	fferential (line	16, 897, 044	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 40.00			USTMENTS			
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	38. 00					38. 00
	39. 00	Program general inpatient routine service cost (line 9 x line	38)			39. 00
41.00   Total Program general inpatient routine service cost (line 39 + line 40)   41.00						
	41. 00	lotal Program general inpatient routine service cost (line 39	+ line 40)		ļ	41.00

	Financial Systems C ATION OF INPATIENT OPERATING COST	CHILDRENS SPECIA		CN: 31-3300	Period:	u of Form CMS Worksheet D-1	
COMPUT	ATION OF INPATIENT OPERATING COST			CCN: 31-3300 CCN: 31-5239	From 01/01/2022 To 12/31/2022	Date/Time Pre	epared:
			Ti tl e	e XVIII	Skilled Nursing Facility	5/25/2023 5: 4 PPS	19 pm
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)						42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	•					43. 00
	CORONARY CARE UNIT						44. 00
45.00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
	cost center bescriptron					1. 00	
48. 00	Program inpatient ancillary service cost (W	kst. D-3, col. 3	3, line 200)	-		11.00	48. 00
	Program inpatient cellular therapy acquisiti	•	·		column 1)		48. 01
49. 00	Total Program inpatient costs (sum of lines	41 through 48.0	01)(see instruc	ctions)			49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inp	natient routine	services (from	n Wkst D sui	m of Parts I and		50.00
00.00	III)	atront routine	301 11 003 (11 01	ii iiitot. D, odi	ii or rares r and		00.00
51. 00	Pass through costs applicable to Program in	oatient ancillar	ry services (fr	om Wkst. D,	sum of Parts II		51.00
F2 00	and IV)	FO and F1)					F2 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non-nhy	usician anest	netist and		52. 00 53. 00
33. 00	medical education costs (line 49 minus line		ratea, non prij	ysi ci aii aiicsti	ictist, and		33.00
	TARGET AMOUNT AND LIMIT COMPUTATION	•					
	Program discharges						54.00
	Target amount per discharge						55. 00 55. 01
	1   Permanent adjustment amount per discharge 2   Adjustment amount per discharge (contractor use only)						55. 02
	Target amount (line 54 x sum of lines 55, 55		)				56. 00
57.00	Difference between adjusted inpatient operat	ting cost and ta	arget amount (I	ine 56 minus	line 53)		57. 00
58. 00	Bonus payment (see instructions)	55.6					58. 00
59. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)		n the cost repo	orting period	enaing 1996,		59. 00
60. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)		om prior year o	cost report,	updated by the		60.00
61.00	Continuous improvement bonus payment (if lir						61.00
	55.01, or line 59, or line 60, enter the les						
	53) are less than expected costs (lines 54 penter zero. (see instructions)	( 60), 01 1 % 01	the target an	nount (Tine 5	o), otherwise		
	Relief payment (see instructions)						62. 00
63. 00	Allowable Inpatient cost plus incentive payr	ment (see instru	uctions)				63.00
( 1 00	PROGRAM INPATIENT ROUTINE SWING BED COST	to through Door	mbox 21 of the	anner t	ing ported (Coo		44.00
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	sts through bece	elliber 31 of the	e cost report	ing perrou (see		64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	sts after Decemb	oer 31 of the d	cost reportin	g period (See		65. 00
// 00	instructions)(title XVIII only)	no costo (lino	(4 plug ling (	(E) (+: +1 a V)/I	II anly). for		// 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	THE COSTS (TITLE	04 prus rine (	os)(title xvi	i i oniy), roi		66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	ne costs through	n December 31 d	of the cost r	eporting period		67. 00
	(line 12 x line 19)						
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	ne costs after L	December 31 of	the cost rep	orting period		68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (	(line 67 + line	e 68)			69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N						
70. 00	Skilled nursing facility/other nursing facil	-			)	16, 897, 044	1
71.00	Adjusted general inpatient routine service of		ine /U ÷ line	2)		1, 047. 36 0	1
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		n (line 14 x li	ne 35)		0	
74. 00	Total Program general inpatient routine serv		•			0	1
75. 00	Capital -related cost allocated to inpatient				Part II, column	0	1
7, 00	26, line 45)	0)					7, 25
76.00	Program capital related costs (line 75 ÷ li					0.00	1
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu					0	
79. 00	Aggregate charges to beneficiaries for excess		provi der record	ds)		0	
	Total Program routine service costs for comp	, ,					80.00

Health Financial Systems CI	HILDRENS SPECIA	LIZED HOPSITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 31-3300 Period:			Worksheet D-1	
		Component (	CCN: 31-5239	From 01/01/2022 To 12/31/2022		
		Title	XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)				0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	0	0	0.00000	0 0	0	90. 00
91.00 Nursing Program cost	0	0	0. 00000	0 0	ol	91. 00
92.00 Allied health cost	0	0	0. 00000	0 0	ol	92.00
93.00 All other Medical Education	0	0	0. 00000	0 0	ol	93. 00

Health Financial Systems	CHILDRENS SPECIALIZ	ZEN HODSITAI	Inlie	u of Form CMS-2	2552_10
COMPUTATION OF INPATIENT OPERATING COST	CHIEDRENS SI ECIALIZ	Provi der CCN: 31-3300	Peri od:	Worksheet D-1	2332-10
COMPUTATION OF INFAITENT OF LIVE COST		FIOVIDEI CCN. 31-3300	From 01/01/2022	WOLKSHEET D-1	
			To 12/31/2022	Date/Time Pre	pared:
				5/25/2023 5: 4	
		Title XIX	Hospi tal	TEFRA	
Cost Center Description					
·				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 19,					1.00

	IITIE XIX   HOSPITAI	IEFRA	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	19, 973	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)  Private room days (excluding swing-bed and observation bed days). If you have only private room days,	19, 973 0	2. 00 3. 00
	do not complete this line.	·	
4.00	Semi-private room days (excluding swing-bed and observation bed days)	19, 973	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	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)		7 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	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 989	9. 00
9.00	newborn days) (see instructions)	1, 707	7.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions)  Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
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)	0	13. 00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14. 00 15. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
40.00	reporting period		40.00
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	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)	35, 053, 117	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6)	0	23. 00
23.00	x line 18)	١	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	X Time 19)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
0, 00	x line 20)		
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	0 35, 053, 117	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	00,000,117	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00		0	
30.00	Semi-private room charges (excluding swing-bed charges)	0 000000	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	1
33. 00 34. 00		0.00	ł
35. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)	0. 00 0. 00	34. 00 35. 00
36. 00	, , ,		36.00
	Private room cost differential adjustment (line 3 x line 35)	0 25 052 117	1
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	35, 053, 117	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 755. 03	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	3, 490, 755	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	3, 490, 755	41. 00

23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
24. 00	X line 18)   Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
26 00	x line 20)   Total swing-bed cost (see instructions)	0	26. 00
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	35, 053, 117	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		34.00
	Average per diem private room cost differential (line 34 x line 31)	0. 00	35.00
	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)	35, 053, 117	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 755. 03	38. 00
	Program general inpatient routine service cost (line 9 x line 38)	3, 490, 755	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3, 490, 755	41.00

			ALIZED HOPSITAL			u of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C		Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Pre 5/25/2023 5:4	pared:
			Ti tl	e XIX	Hospi tal	TEFRA	у ріп
	Cost Center Description	Total Inpatient Cos	Total tInpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)						42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43.00
	CORONARY CARE UNIT						44. 00
	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
	<u> </u>					1. 00	
	Program inpatient ancillary service cost (Wk			III lino 10	column 1)	1, 179, 537	48. 00 48. 01
	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				corumn 1)	0 4, 670, 292	
	PASS THROUGH COST ADJUSTMENTS	<b>-</b>	, ,	•		.,,	1
50.00	Pass through costs applicable to Program inp	atient routine	e services (from	n Wkst. D, sum	of Parts I and	122, 184	50.00
51. 00	<pre>III) Pass through costs applicable to Program inp</pre>	atient ancilla	nrv services (fr	om Wkst. D. s	um of Parts II	37, 023	51.00
	and IV)		,	2.2. 2, 0			
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		alatad nan nhu	voi oi on oncoth	otiot and	159, 207	
33.00	medical education costs (line 49 minus line		erateu, non-pny	/Si Ci ali aliestii	letist, and	4, 511, 085	33.00
	TARGET AMOUNT AND LIMIT COMPUTATION	,					
	Program di scharges					124 404 27	
	Target amount per discharge Permanent adjustment amount per discharge					136, 696. 37 0. 00	1
	Adjustment amount per discharge (contractor	use only)				0. 00	1
	Target amount (line 54 x sum of lines 55, 55				50)	4, 100, 891	1
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	-410, 194 0	1				
							59.00
	updated and compounded by the market basket)						
60. 00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						60.00
61.00	Continuous improvement bonus payment (if lin					0	61.00
	55.01, or line 59, or line 60, enter the les						
	53) are less than expected costs (lines 54 x enter zero. (see instructions)	60), or 1 % (	or the target an	mount (Tine 56	o), otherwise		
	Relief payment (see instructions)					53	1
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instr	ructions)			4, 260, 151	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dec	cember 31 of the	e cost reporti	ng period (See	0	64. 00
	instructions)(title XVIII only)	-					
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decem	nber 31 of the d	cost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	e 64 plus line 6	55)(title XVII	I only); for	0	66. 00
<b>/7</b> 00	CAH, see instructions		- D	.e		0	/7.00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs turou(	Ji December 31 C	or the cost re	portring period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after	December 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs	(line 67 + line	- 68)		0	69.00
07.00	PART III - SKILLED NURSING FACILITY, OTHER N						07.00
	Skilled nursing facility/other nursing facil	•					70.00
	Adjusted general inpatient routine service c Program routine service cost (line 9 x line	•	line /U ÷ line	2)			71.00
	Medically necessary private room cost applic		nm (line 14 x li	ne 35)			73. 00
	Total Program general inpatient routine serv						74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine servic	ce costs (from V	Vorksheet B, P	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
	Program capital -related costs (line 9 x line						77. 00
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		provi den record	ds)			78. 00 79. 00
	Total Program routine service costs for comp		•		us line 79)		80.00
81.00	Inpatient routine service cost per diem limi	tati on			ŕ		81.00
	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (						82. 00 83. 00
	Program inpatient ancillary services (see in		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				84.00
85.00	Utilization review - physician compensation	(see instructi					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS						86. 00
						0	07.00
87. 00	Total observation bed days (see instructions	)				0	87.00

Heal th	Financial Systems C	HILDRENS SPECIA	LIZED HOPSITAL		In Lie	eu of Form CMS-	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
					From 01/01/2022 To 12/31/2022		
			Titl	e XIX	Hospi tal	TEFRA	
	Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
			(from line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
		1.00	2.00	3.00	4. 00	5. 00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00	Capital -related cost	1, 227, 017	35, 053, 117	0. 03500	5 0	0	90.00
91.00	Nursing Program cost	0	35, 053, 117	0. 00000	0 0	0	91.00
92.00	Allied health cost	0	35, 053, 117	0. 00000	0 0	0	92.00
93.00	All other Medical Education	0	35, 053, 117	0. 00000	0 0	0	93. 00

Health Financial Systems CHILDRENS SPECIALIZ	ZED HOPSITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co		Peri od:	Worksheet D-3	
			From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 5:4	
	Title	XVIII	Hospi tal	TEFRA	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1. 00	2. 00	3. 00	
30. 00   03000   ADULTS & PEDIATRICS		1	121, 800		30.00
ANCI LLARY SERVI CE COST CENTERS			121,000		30.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11754	.7	0	54.00
60. 00   06000   LABORATORY		0.04519		122	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000		0	
65, 00 06500 RESPIRATORY THERAPY		0. 23024		0	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 68616	6, 482	4, 448	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 59218	5, 483	3, 247	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 54053	11, 225	6, 067	68. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 52904	3 0	0	71. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS		1. 18485		3, 250	73. 00
76. 00   03550   MEDI CAL   SERVI CES		21. 36558		0	
76. 01   03950   PSYCHI ATRI C		0. 66471		0	
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 00000		0	
76. 98 O7698 HYPERBARI C OXYGEN THERAPY		0. 00000		0	
76. 99   07699 LI THOTRI PSY		0. 00000		0	
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON		0. 00000	00 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS  90.00   O9000  CLINIC		0.5/01/	10		00.00
		0. 56212 0. 00000		0	
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART 93. 00   04950   SCHOOL BASED PROGRAMS		0.00000		-	
93. 99   09399   PARTI AL HOSPI TALI ZATI ON PROGRAM		0.00000		0	93.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0.00000	28, 639	_	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		20, 039	17, 134	201. 00
202.00 Net charges (line 200 minus line 201)	(TITIE OI)		28, 639		202.00
202.00		ı	20,007	I	1202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od: From 01/01/2022	Worksheet D-3	
			To 12/31/2022		
				5/25/2023 5: 4	9 pm
	Titl	e XIX	Hospi tal	TEFRA	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			7, 640, 119		30.00
ANCI LLARY SERVI CE COST CENTERS		1	7,010,117		
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11754	47 866	102	54.00
60. 00 06000 LABORATORY		0. 04519		1, 886	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000	00	0	62. 30
65. 00 06500 RESPI RATORY THERAPY		0. 23024	1, 055, 546	243, 031	65.00
66. 00   06600   PHYSI CAL THERAPY		0. 68616	62 156, 730	107, 542	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 59218	158, 287	93, 735	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 54053	34 460, 517	248, 925	68.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 52904			
73. 00 O7300 DRUGS CHARGED TO PATIENTS		1. 18485		369, 642	73.00
76. 00   03550   MEDI CAL   SERVI CES		21. 36558	30 0	0	76.00
76. 01   03950   PSYCHI ATRI C		0. 6647		3, 577	
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 00000		0	1 , 0, , ,
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0.00000		0	
76. 99 07699 LI THOTRI PSY		0. 00000		0	
77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION		0. 00000	00 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS		1 0 5/04/		4.7.0	
90. 00 09000 CLINIC		0. 56212		14, 740	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.00000		0	1
93. 00   04950   SCHOOL BASED PROGRAMS		0.00000		0	
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM		0.00000		1 170 527	1 ,0, ,,
Total (sum of lines 50 through 94 and 96 through 98)	- (1: (1)		2, 280, 273	1, 179, 537	
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		2 200 272		201. 00
202.00 Net charges (line 200 minus line 201)		1	2, 280, 273		202. 00

Health Financial Systems	CHILDRENS SPECIALIZED HOPSITA	In Lie	u of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 31-3300		Worksheet E Part B Date/Time Prepared: 5/25/2023 5:49 pm
	T			TEEDA

	Title XVIII Hos	pi tal	5/25/2023 5: 4 TEFRA	9 pm
	II LI E AVIII   NOS	ргтаг	TEFRA	
	DADT D. MEDICAL AND OTHER HEALTH CERVICES		1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES  Medical and other services (see instructions)		336	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)		43, 704	2. 00
3.00	OPPS payments		22, 430	3. 00
4. 00 4. 01	Outlier payment (see instructions)		0	4. 00 4. 01
5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructions)		0. 961	5. 00
6.00	Line 2 times line 5		42, 000	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		53. 40	7. 00
8.00	Transitional corridor payment (see instructions)		19, 570	
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions		0	9. 00 10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)		336	
	COMPUTATION OF LESSER OF COST OR CHARGES			
12.00	Reasonable charges		F00	12.00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		598	12. 00 13. 00
	Total reasonable charges (sum of lines 12 and 13)			14. 00
	Customary charges			
15. 00	1 3 3		0	
16. 00	Amounts that would have been realized from patients liable for payment for services on a char had such payment been made in accordance with 42 CFR §413.13(e)	gebasis	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)		598	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11)	see	262	19. 00
20. 00	<pre>instructions) Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18)</pre>	See.	0	20. 00
20.00	instructions)	,366		20.00
21. 00	Lesser of cost or charges (see instructions)		336	
	Interns and residents (see instructions)		0	22. 00
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instructions) Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		42, 000	23. 00 24. 00
21.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		12,000	21.00
	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		6, 718	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] instructions)	(See	35, 618	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29. 00
30.00	Subtotal (sum of lines 27 through 29)		35, 618	
	Primary payer payments Subtotal (line 30 minus line 31)		0 35, 618	31. 00 32. 00
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		00,010	02.00
	Composite rate ESRD (from Wkst. I-5, line 11)		0	33. 00
	Allowable bad debts (see instructions)		0	34. 00
36. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions)		0	35. 00 36. 00
37. 00	, , ,		35, 618	
	MSP-LCC reconciliation amount from PS&R		0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39. 00
39. 50 39. 75	Pioneer ACO demonstration payment adjustment (see instructions)  N95 respirator payment adjustment amount (see instructions)		0	39. 50 39. 75
39. 97	Demonstration payment adjustment amount before sequestration			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 40. 01	Subtotal (see instructions)   Sequestration adjustment (see instructions)		35, 618 449	
40. 01	Demonstration payment adjustment amount after sequestration		0	
	Sequestration adjustment-PARHM or CHART pass-throughs			40. 03
	Interim payments		15, 547	41.00
41. 01	Interim payments-PARHM or CHART Tentative settlement (for contractors use only)		0	41. 01 42. 00
42. 00	Tentative settlement-PARHM or CHART (for contractor use only)			42. 00
43. 00	Balance due provider/program (see instructions)		19, 622	
43. 01	Balance due provider/program-PARHM (see instructions)			43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 5115-2	1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR			
90.00	Original outlier amount (see instructions)		0	90. 00
91. 00	Outlier reconciliation adjustment amount (see instructions)		0	
	The rate used to calculate the Time Value of Money			92.00
93. 00 94. 00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)		0	93. 00 94. 00
			,	

Health Financial Systems	th Financial Systems CHILDRENS SPECIALIZED HOPSITAL In Lie			u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Peri od:	Worksheet E	
			From 01/01/2022		
			To 12/31/2022	Date/Time Pr	epared:
				5/25/2023 5:	49 pm
		Title XVIII	Hospi tal	TEFRA	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				(	0 200. 00

Health Financial Systems CHILDRI ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 31-3300

					5/25/2023 5: 49	9 pm
		Title	XVIII	Hospi tal	TEFRA	
		I npati en	t Part A	Par	rt 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		50, 6	16	15, 547	1. 00
2.00	Interim payments payable on individual bills, either			0	o	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	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)					
	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
2 50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	2 50
3. 50 3. 51	ADJUSTMENTS TO PROGRAM			0	0	3. 50 3. 51
3. 51				0		3. 51
3. 52				0		3. 52
3. 54				0		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		3. 99
3. 77	3. 50-3. 98)			O .	١	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		50, 6°	16	15, 547	4.00
00	(transfer to Wkst. E or Wkst. E-3, line and column as		00,0		10,017	00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5. 03				0	0	5. 03
F F0	Provi der to Program					F F0
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51 5. 52
5. 52 5. 99				0		5. 52 5. 99
5. 99	5. 50-5. 98)			U	ا	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER			0	19, 622	6. 01
6. 02	SETTLEMENT TO PROGRAM		3. 9	-	17,022	6. 02
7. 00	Total Medicare program liability (see instructions)		46, 70		35, 169	7. 00
7.00	Total mod. od. o program redoring (occ restractions)		15, 70	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2.00	
8.00	Name of Contractor					8. 00

Health Financial Systems	CHILDRENS SPECIALIZED HOPSITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-3300		Worksheet E-3 Part I Date/Time Prepared: 5/25/2023 5:49 pm

			10 12/31/2022	5/25/2023 5: 4	
		Title XVIII	Hospi tal	TEFRA	
				1. 00	
	PART I - MEDICARE PART A SERVICES - TEFRA				
1.00	Inpatient hospital services (see instructions)			69, 859	1. 00
1.01	Nursing and allied health managed care payment (see instructio	ns)		0	1. 01
2.00	Organ acqui si ti on			0	2. 00
3.00	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	3. 00
4.00	Subtotal (sum of lines 1 through 3)			69, 859	4. 00
5.00	Primary payer payments			0	5. 00
6.00	Subtotal (line 4 less line 5).			69, 859	6. 00
7.00	Deducti bl es			0	7. 00
8.00	Subtotal (line 6 minus line 7)			69, 859	8. 00
9.00	Coinsurance			22, 562	9. 00
10.00	Subtotal (line 8 minus line 9)			47, 297	
	Allowable bad debts (exclude bad debts for professional servic	es) (see instructions)		0	11. 00
12.00	Adjusted reimbursable bad debts (see instructions)			0	12. 00
13.00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		0	13. 00
14. 00	Subtotal (sum of lines 10 and 12)			47, 297	
15. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 49)		0	10.00
	DO NOT USE THIS LINE				16. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instructions	)		0	17.00
	Recovery of accelerated depreciation.			0	
17. 99	Demonstration payment adjustment amount before sequestration			0	17. 99
18. 00	Total amount payable to the provider (see instructions)			47, 297	
18. 01	Sequestration adjustment (see instructions)			596	
18. 02	Demonstration payment adjustment amount after sequestration			0	18. 02
	Interim payments			50, 616	
20.00	Tentative settlement (for contractor use only)			0	20. 00
21. 00	Balance due provider/program (line 18 minus lines 18.01, 18.02			-3, 915	
22. 00	Protested amounts (nonallowable cost report items) in accordan §115.2	ce with CMS Pub. 15-2,	chapter 1,	0	22. 00

Heal th	Financial Systems CHILDRENS SP	PECIALIZED HOPSITAL	In Lie	u of Form CMS-2	2552-10		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-3300	Peri od: From 01/01/2022	Worksheet E-3 Part VI			
		Component CCN: 31-5239	To 12/31/2022		pared:		
				5/25/2023 5: 4			
		Title XVIII	Skilled Nursing	PPS			
			Facility				
				1.00			
	DART VI CALOULATION OF RELIBURCHIENT CETTLEMENENT A	ALL OTHER HEALTH CERVILORS FOR T	LTLE VALLE DADT A	1. 00			
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - A SERVICES	ALL UTHER HEALTH SERVICES FOR T	TILE XVIII PART A	PPS SINF			
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)						
1.00	Resource Utilization Group Payment (RUGS)			0	1.00		
2.00	Routine service other pass through costs			0	2. 00		
3.00	Ancillary service other pass through costs			0	3. 00		
4.00	Subtotal (sum of lines 1 through 3)			0	4. 00		
	COMPUTATION OF NET COST OF COVERED SERVICES						
5.00	Medical and other services (Do not use this line as vac	ccine costs are included in lin	e 1 of W/S E,		5. 00		
	Part B. This line is now shaded.)						
6.00	Deducti bl e			0	6. 00		
7. 00	Coinsurance			0	7. 00		
	Allowable bad debts (see instructions)			0	8. 00		
9. 00	Reimbursable bad debts for dual eligible beneficiaries	(see instructions)		0	9. 00		
10.00	Adjusted reimbursable bad debts (see instructions)			0	10.00		
	Utilization review			0	11. 00		
	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus l	ines 10 and 11)(see instructio	ns)	0	12. 00		
	Inpatient primary payer payments			0	13.00		
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	14.00		
	Pioneer ACO demonstration payment adjustment (see instr	ructions)		0	14. 50		
14. 98	8 Recovery of accelerated depreciation.						

14. 99

0 15.02

15. 75 16. 00 17. 00

18.00

19.00

0 15.00

0 15.01

0

0

14.99 Demonstration payment adjustment amount before sequestration

15.02 Demonstration payment adjustment amount after sequestration

15.75 | Sequestration for non-claims based amounts (see instructions)

Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)

19.00 Protested amounts (nonal lowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1,

Subtotal (see instructions

15.01 | Sequestration adjustment (see instructions)

16.00 Interim payments
17.00 Tentative settlement (for contractor use only)

15.00

18.00

Health Financial Systems	CHILDRENS SPECIALIZED HOPSITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-3300	From 01/01/2022	Worksheet E-3 Part VII Date/Time Prepared:

			To 12/31/2022	Date/Time Pre 5/25/2023 5:4	
		Title XIX	Hospi tal	772372023 3. 4 TEFRA	у рііі
		II ti c XIX	I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	/ICES FOR TITLES V OR XI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	THE TON THEE TON ALL	. 02.1111 020		
1.00	Inpatient hospital/SNF/NF services		4, 260, 151		1.00
2. 00	Medical and other services		1,200,101	4, 529, 337	2. 00
3. 00	Organ acquisition (certified transplant programs only)		o	.,,	3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		4, 260, 151	4, 529, 337	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		4, 260, 151	4, 529, 337	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		7, 640, 119		8. 00
9.00	Ancillary service charges		2, 280, 273	7, 054, 606	9. 00
10.00	Organ acquisition charges, net of revenue		0		10. 00
			0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		9, 920, 392	7, 054, 606	12. 00
	CUSTOMARY CHARGES				
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis		_	_	
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
15 00	a charge basis had such payment been made in accordance with 42	2 CFR §413. 13(e)	0.000000	0.000000	15 00
15. 00 16. 00	Ratio of line 13 to line 14 (not to exceed 1.000000) Total customary charges (see instructions)		0. 000000 9, 920, 392	0. 000000 7, 054, 606	1
17. 00	Excess of customary charges over reasonable cost (complete only	wifling 16 avenues	5, 660, 241	2, 525, 269	1
17.00	line 4) (see instructions)	y II IIIle 16 exceeds	5, 660, 241	2, 323, 209	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	vifline 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)	y II IIIIc 4 cxcccd3 IIIIc		O	10.00
19. 00	Interns and Residents (see instructions)		o	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instru	uctions)	o	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16		4, 260, 151	4, 529, 337	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be of		ers.	· · · · · · · · · · · · · · · · · · ·	
22. 00	Other than outlier payments		0	0	22. 00
23.00	Outlier payments		0	0	23. 00
24.00	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	,		4, 260, 151	4, 529, 337	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30. 00	Excess of reasonable cost (from line 18)		0	0	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		4, 260, 151	4, 529, 337	
32. 00	Deducti bl es		0	0	
33. 00			0	0	
34. 00	,		0	0	
35. 00	Utilization review		4 240 151	4 520 227	35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) D-3 ADJUSTMENT		4, 260, 151	4, 529, 337 447, 471	
			4, 260, 151	4, 976, 808	1
	Subtotal (line 36 ± line 37)		4, 200, 151	4, 7/0, 008	39.00
40. 00	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)		4, 260, 151	4, 976, 808	
41. 00	Interim payments		6, 740, 775	3, 976, 985	•
42. 00	Balance due provider/program (line 40 minus line 41)		-2, 480, 624	999, 823	
43. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2	-2, 400, 024	777, 023	43. 00
.5. 55	chapter 1, §115.2			O	.5. 55
			'		'

BINTCT (SARDMET WITHCAL FRUCATION (GWP) & ISSID DUPPATIENT DIRECT   Provider CDE 31.3300	Heal th	Financial Systems CHILDRENS SPECIALI.	ZED HOPSITAL		In Lie	u of Form CMS-2	2552-10
Title XVIII		· · · · · · · · · · · · · · · · · · ·	Provi der CO	CN: 31-3300		Worksheet E-4	
1.00	WEDI CA	L EDUCATION COSTS					
DOBBITATION OF TOTAL DIRECT GUE MOUNT			Title	XVIII	Hospi tal	TEFRA	
Dimpelighted resident FIE count for all opathic and esteopathic programs for cost reporting periods ending on are before becember 31 of the CAA 2021 (see Instructions)   0.00   1.01						1. 00	
ending on or before December 31, 1996.	1 00		nrograms for	cost reporti	na periode	0.00	1 00
Unweighted FTF resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)   0.00   2.00	1.00		programs ron	Cost Tepol ti	rig per rous	0.00	1.00
2.28   Rural Track program FIE cap I imitation adjustment affer the cap-building window closed under \$127 of the CAA 2021 (see instructions)   0.00   3.01							
the CAA 2021 (see instructions) 3.00 3.00 birrect GME cap reduction amount under Ack 5503 in accordance with 42 CFR §413.79 (m). (see						0.00	
Direct CME cap reduction amount under AAA \$5503 in accordance with 42 CFR \$413.79 (m). (see instructions for cost reporting periods stradding 771/2011)   Adjustment (Increase or decrease) to the hospital's rural track FIE limitation(s) for rural track programs with a rural track Medicare CME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see Instructions)   4.00   Adjustment (plus or minus) to the FIE cap for all opathic and osteopathic programs due to a Medicare CME affiliation agreement (12 CFR \$413.79 (f))   4.01   ACA Section 5503 increase to the Direct CME FTE cap (see instructions for cost reporting periods stradding 771/2011)   4.12   ACA Section 5503 increase to the Direct CME FTE cap slots (see instructions for cost reporting and the cost of the cost	2. 20		ap-builtuilig	willdow crosec	r under 3127 of		2. 20
instructions for cost reporting periods straddling 771/2011)  2. Adjustment (increase or decrease) to the hospital' srural 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)  4. On Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare  6. Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare  6. Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare  7. On Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare  8. On Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare  9. On Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs for the CAA 2021 (see instructions)  9. On Enter the lesser of line 5 or line 6  9. On Enter the lesser of line 5 or line 6  9. On Enter the lesser of line 5 or line 6  9. On		•			,		
3.02   Adjustment (increase or decrease) to the hospital's rural track programs with a rural track and care (ME affiliation agreement in accordance with 413.76 (b) and 87 FR 49075 (August 10, 2022) (see instructions)   4.00	3. 01		with 42 CFR	§413.79 (m).	(see	0.00	3. 01
49075 (August 10, 2022) (see instructions) 4.00 Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare 6.00 (A. 00 Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare 6.01 (ACA Section 5500 increase to the Direct GME FTE Cap (see instructions for cost reporting periods 7.02 (ACA Section 5500 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011) 4. 2 (ACA Section 5500 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011) 5. 2 (ACA Section 5500 number of additional direct GME FTE cap slots under \$126 of the CAA 2021 (see instructions) 6. 3 (A) plus or minus line 3.02, plus or minus 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 6. 0 (A)	3. 02		ck FTE limit	ation(s) for	rural track		3. 02
Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare (AME AFTILIATION agreement (42 CFR §413.75(b) and § 413.79 (T))  ACA Section 5503 increase to the Direct GME FTE cap (see Instructions for cost reporting periods straddling 71/2011)  ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 71/2011)  The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see Instructions)  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  [Body Barry 1			t in accorda	nce with 413.	75(b) and 87 FR		
College	4.00		osteopathi c	programs due	to a Medicare	0.00	4. 00
straddling 7/1/2011) 4.02 ACS Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011) 4.1 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions) 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 6.00 Unwelghted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions) 7.00 Enter the lesser of line 5 or line 6 8.00 Welghted FTE count for physicians in an allopathic and osteopathic programs for the current year from your program for the current year. 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 Morksheet 5-2, Part 1, line 68, is "", see instructions 10.00 Welghted dental and podiatric resident FTE count for the current year 0.00 0.00 10.01 Unwelghted dental and podiatric resident FTE count for the current year 0.00 0.00 11.00 1.01 Unwelghted dental and podiatric resident FTE count for the current year 0.00 0.00 11.00 1.01 1.00 1.01 1.00		GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)	)	. 0			
ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddiling 771/2011)  4. 21 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions)  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 4.02, plus or minus line 4.00, plus or minus line 4.00 plus lines 4.01 through 4.27  6. 00 Unwelghted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)  8. 00 Welghted FTE count for physicians in an allopathic and osteopathic programs for the current year.  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 lif Worksheet S-2, Part I, line 68, is "Y", see instructions.  10. 00 Weighted dental and podiatric resident FTE count for the current year  10. 01 Unwelghted dental and podiatric resident FTE count for the current year  10. 01 Unwelghted dental and podiatric resident FTE count for the current year  10. 01 Total weighted FTE count (sum of lines 11 through 13 divided by 3).  12. 00 Total weighted resident FTE count for the prior cost reporting year (see instructions)  13. 00 Total weighted resident FTE count for the programs  14. 00 Rolling average FTE count (sum of lines 11 through 13 divided by 3).  15. 01 Unweighted adjustment for residents in initial years of new programs  16. 01 Unweighted adjustment for residents displaced by program or hospital closure  17. 00 Losure  18. 01 Unweighted aljustment for residents displaced by program or hospital closure  18. 00 Unweighted adjustment for residents of the CAA 2021  18. 00 Unweighted adjustment for residents of the CAA 2021  18. 00 Unweighted adjustment for r	4. 01	1 ,	ructions for	cost reporti	ng periods	0. 00	4. 01
1.00   Weighted FTE count for physicians in an aliopathic and osteopathic program for the current year form your program for the current year.   2.51   2.90   5.41   8.00   Weighted FTE count for physicians in an aliopathic and osteopathic programs for the current year from your program for the current year from your program for the current year from your program for the lesser of line 5 or line 6   Primary Care   Other   Total   1.00   2.00   3.00   7.00	4. 02		s (see inst	ructions for	cost reporting	0. 00	4. 02
Instructions   1		, ,					
FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.0, plus or minus line 4.0 plus lines 4.01 through 4.27	4. 21		ots under §1	26 of the CAP	2021 (see		4. 21
Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)   0.00 7.00	5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lin			ius lines 3 and	0. 00	5. 00
Primary Care	6 00				woar from your	5.07	6 00
Note	0.00					5. 47	0.00
8.00 Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.  9.00 If line 6 is less than 5 enter the amount from line 8, otherwise of 1 in line 8 is less than 5 enter the amount from line 8, otherwise of 1 in line 9, otherwise of 1 in line 2 is limes 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 5-2, Part 1, line 68, is "Y", see instructions.  10.00 Weighted dental and podiatric resident FTE count for the current year 0.00 0.00 10.01 11.00 11.00	7. 00	Enter the lesser of line 5 or line 6					7. 00
Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.							
9.00 if in 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.  10.00 line wighted dental and podiatric resident FTE count for the current year 0.00 10.01 11.00	8. 00		athi c				8. 00
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.  10.00 Weighted dental and podiatric resident FTE count for the current year 0.00 10.01 Unweighted dental and podiatric resident FTE count for the current year 0.00 10.01 11.00 Total weighted FTE count for the prior cost reporting year (see 2.29 3.74 12.00 Total weighted resident FTE count for the prior cost reporting year (see instructions)  13.00 Total weighted resident FTE count for the penultimate cost reporting 3.70 3.51 13.00 year (see instructions)  14.00 Rolling average FTE count (sum of lines 11 through 13 divided by 3). 2.00 2.42 14.00 Rolling average FTE count (sum of lines 11 through 13 divided by 3). 2.00 0.00 15.00 Unweighted adjustment for residents in initial years of new programs 0.00 0.00 15.00 Howeighted adjustment for residents displaced by program or hospital closure 0.00 0.00 16.00 Roll Unweighted adjustment for residents displaced by program or hospital 0.00 0.00 0.00 16.00 Unweighted adjustment for residents displaced by program or hospital 0.00 0.00 0.00 16.00 Roll Unweighted adjustment for residents displaced by program or hospital 0.00 0.00 0.00 16.00 Roll Unweighted adjustment for residents displaced by program or hospital 0.00 0.00 0.00 16.00 Roll Unweighted amount 0.00 0.00 0.00 16.00 Roll Unweighted amount 0.00 0.00 0.00 0.00 18.00 Per resident amount under §131 of the CAA 2021 18.01 Per resident amount under §131 of the CAA 2021 18.01 Per resident count over cap (see instructions) 5.97 21.00 Direct GME FTE unweighted resident count over cap (see instructions) 5.97 21.00 Per the locality adjustment national average per resident amount (see instructions) 0.00 22.00 24.00 Multiply line 22 time line 23 0.24.00 Multiply line 22 time line 23 0.24.00	0.00		iso	0.0	0.00	0.00	0 00
if Worksheet S-2, Part I, line 68, is "Y", see instructions.  Weighted dental and podiatric resident FTE count for the current year  10.00 Unweighted dental and podiatric resident FTE count for the current year  10.00 10.01  10.01 Total weighted FTE count  10.00 0.00 0.00 0.00  11.00  12.00 Total weighted resident FTE count for the prior cost reporting year (see instructions)  13.00 Total weighted resident FTE count for the penultimate cost reporting year (see instructions)  14.00 Rolling average FTE count (sum of lines 11 through 13 divided by 3).  15.01 Unweighted adjustment for residents in initial years of new programs  16.01 Unweighted adjustment for residents in initial years of new programs  17.00 Adjustment for residents displaced by program or hospital closure  18.00 Unweighted adjustment for residents displaced by program or hospital closure  18.01 Unweighted adjustment for residents displaced by program or hospital closure  18.00 Per resident amount under §131 of the CAA 2021  19.00 Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42  20.00 2.00 Additional unweighted resident count over cap (see instructions)  10.00 Calcoling the count of the count of the current year  10.00 0.00 0.00 0.00 0.00 0.00 0.00 0.	7. 00			0.0	0.00	0.00	9.00
10.00   Weighted dental and podiatric resident FTE count for the current year   0.00   10.01   10.00   10.01   10.00   10.01   10.00   10.01   10.00   10.01   10.00   10.00   10.00   10.01   10.00			, 2022, or				
10. 01 Unweighted dental and podiatric resident FTE count for the current year 0.00 0.00 11. 00 17 total weighted FTE count for the prior cost reporting year (see instructions) 12. 00 Total weighted resident FTE count for the prior cost reporting year (see instructions) 13. 00 Total weighted resident FTE count for the penultimate cost reporting 3. 70 3. 51 12. 00 year (see instructions) 14. 00 Rolling average FTE count (sum of lines 11 through 13 divided by 3). 2. 00 2. 42 14. 00 Rolling average FTE count (sum of lines 11 through 13 divided by 3). 2. 00 0. 00 0. 00 15. 00 15. 00 15. 00 16. 00 16. 00 16. 00 17.	10 00		ent vear		0.00		10 00
12.00 Total weighted resident FTE count for the prior cost reporting year (see instructions)  13.00 Total weighted resident FTE count for the penultimate cost reporting year (see instructions)  14.00 Rolling average FTE count (sum of lines 11 through 13 divided by 3).  15.00 Adjustment for residents in initial years of new programs  15.00 Adjustment for residents in initial years of new programs  16.00 Adjustment for residents displaced by program or hospital closure  17.00 Adjustment for residents displaced by program or hospital closure  18.00 Unweighted adjustment for residents displaced by program or hospital  18.00 Per resident amount  19.00 Adjusted rolling average FTE count  19.00 Adjusted rolling average FTE count  19.00 Adjusted rolling average FTE count  19.00 Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42  20.00 2.42  10.00 Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42  20.00 Additional unweighted resident count over cap (see instructions)  10.00 Direct GME FTE unweighted resident count over cap (see instructions)  10.00 Closure  10.00 Additional unweighted resident count over cap (see instructions)  10.00 Closure  10.00 Additional unweighted resident count over cap (see instructions)  10.00 Closure  10.00 Additional unweighted resident count over cap (see instructions)  10.00 Closure  10.00 Additional unweighted resident count over cap (see instructions)  10.00 Closure  10.00 Additional unweighted resident count over cap (see instructions)  10.00 Closure  10.00 Additional unweighted resident count over cap (see instructions)  10.00 Closure  10.00 Additional unweighted resident count over cap (see instructions)  10.00 Closure  10.00 Additional unweighted resident count over cap (see instructions)  10.00 Closure  10.00 Additional unweighted resident count over cap (see instructions)  10.00 Closure  10.00 C							
instructions) Total weighted resident FTE count for the penultimate cost reporting year (see instructions)  14.00 Rolling average FTE count (sum of lines 11 through 13 divided by 3).  15.00 Adjustment for residents in initial years of new programs  15.01 Unweighted adjustment for residents in initial years of new programs  16.00 Adjustment for residents displaced by program or hospital closure  17.00 Adjustment for residents displaced by program or hospital closure  18.00 Unweighted adjustment for residents displaced by program or hospital closure  19.00 Per resident amount  19.00 Per resident amount  19.00 Approved amount for resident costs  10.00 O O O O O O O O O O O O O O O O O O			,				
13.00 Total weighted resident FTE count for the penultimate cost reporting year (see instructions)  14.00 Rolling average FTE count (sum of lines 11 through 13 divided by 3).  15.00 Adjustment for residents in initial years of new programs  16.00 Adjustment for residents displaced by program or hospital closure  16.01 Unweighted adjustment for residents displaced by program or hospital closure  17.00 Adjusted rolling average FTE count  18.00 Per resident amount  18.00 Per resident amount  19.00 Approved amount for resident costs  10.00 Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42  20.00 Additional unweighted resident count over cap (see instructions)  20.00 Allowable additional direct GME FTE Resident Count (see instructions)  21.00 Enter the locality adjustment national average per resident amount (see instructions)  22.00 Closure  23.00 Closure  24.00 Olicinal unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42  25.00 Closure  26.00 Closure  27.00 Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42  28.00 Closure  29.00 Closure  20.00 Additional unweighted resident count over cap (see instructions)  29.00 Allowable additional direct GME FTE Resident Count (see instructions)  29.00 Closure  20.00 Closure  20	12. 00		g year (see	2. 2	3. 74		12. 00
14.00 Rolling average FTE count (sum of lines 11 through 13 divided by 3).  15.00 Adjustment for residents in initial years of new programs  16.00 Adjustment for residents in initial years of new programs  16.00 Adjustment for residents displaced by program or hospital closure  16.01 Unweighted adjustment for residents displaced by program or hospital closure  17.00 Adjusted rolling average FTE count  18.00 Per resident amount  19.00 Approved amount for resident costs  10.00 Company or hospital  18.01 Per resident amount under §131 of the CAA 2021  19.00 Approved amount for resident costs  10.00 Company or hospital  10.00 Company or h	13. 00		porti ng	3. 7	70 3. 51		13. 00
15.00 Adj ustment for residents in initial years of new programs  0.00 0.00  15.01 Unweighted adj ustment for residents in initial years of new programs  0.00 0.00  15.01  16.00 Adj ustment for residents displaced by program or hospital closure  0.00 0.00  16.01 Unweighted adj ustment for residents displaced by program or hospital closure  17.00 Unweighted adj ustment for residents displaced by program or hospital closure  17.00 Adj usted rolling average FTE count  17.00 Per resident amount  18.01 Per resident amount under §131 of the CAA 2021  19.00 Approved amount for resident costs  10.00  10.00  11.0	44.00						
15. 01 Unweighted adjustment for residents in initial years of new programs  15. 01 do 00 do 0. 00 do			by 3).				
16.01 Unweighted adjustment for residents displaced by program or hospital 0.00 0.00 16.01 17.00 Adjusted rolling average FTE count 2.00 2.42 17.00 18.00 Per resident amount Per resident amount under §131 of the CAA 2021 18.01 Per resident amount for resident costs 0 0 0 0 0 19.00 18.00 Approved amount for resident costs 0 0 0 0 0 19.00 19.00 20.00 Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 0.00 20.00 Sec. 413.79(c)(4) 21.00 Direct GME FTE unweighted resident count over cap (see instructions) 5.97 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			rograms				
closure Adjusted rolling average FTE count 2.00 2.42 17.00 18.00 Per resident amount Per resident amount under §131 of the CAA 2021 19.00 Approved amount for resident costs  0 0 0 0 19.00  20.00 Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4) 21.00 Direct GME FTE unweighted resident count over cap (see instructions) 31.00 22.00 Allowable additional direct GME FTE Resident Count (see instructions) 32.00 Enter the locality adjustment national average per resident amount (see instructions) 32.00 Multiply line 22 time line 23							
17. 00 Adjusted rolling average FTE count  18. 00 Per resident amount  19. 00 Per resident amount under §131 of the CAA 2021  19. 00 Approved amount for resident costs  10 0 0 0 0 19. 00  20. 00 Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 sec. 413. 79(c) (4)  21. 00 Direct GME FTE unweighted resident count over cap (see instructions)  22. 00 Allowable additional direct GME FTE Resident Count (see instructions)  23. 00 Enter the locality adjustment national average per resident amount (see instructions)  24. 00 Multiply line 22 time line 23	16. 01		ospi tal	0.0	0.00		16. 01
18. 01 Per resident amount under §131 of the CAA 2021  19. 00 Approved amount for resident costs  1. 00  20. 00 Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42  20. 00 Direct GME FTE unweighted resident count over cap (see instructions)  22. 00 Allowable additional direct GME FTE Resident Count (see instructions)  23. 00 Enter the locality adjustment national average per resident amount (see instructions)  24. 00 Multiply line 22 time line 23	17. 00			2.0	2. 42		17. 00
19.00 Approved amount for resident costs  0 0 0 19.00  20.00 Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 0.00 20.00 Sec. 413.79(c)(4)  21.00 Direct GME FTE unweighted resident count over cap (see instructions)  22.00 Allowable additional direct GME FTE Resident Count (see instructions)  23.00 Enter the locality adjustment national average per resident amount (see instructions)  0 0 0 19.00  1.00  20.00 20.00  21.00 Allowable additional direct GME FTE Resident Count (see instructions)  0.00 22.00  23.00 Multiply line 22 time line 23				0.0	0.00		
20.00 Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 0.00 20.00 Sec. 413.79(c)(4) 21.00 Direct GME FTE unweighted resident count over cap (see instructions) 5.97 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					0	0	
20.00 Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4) 21.00 Direct GME FTE unweighted resident count over cap (see instructions) 5.97 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	17.00	The restaurt costs			<u> </u>	0	17.00
Sec. 413.79(c)(4)  21.00 Direct GME FTE unweighted resident count over cap (see instructions)  22.00 Allowable additional direct GME FTE Resident Count (see instructions)  23.00 Enter the locality adjustment national average per resident amount (see instructions)  24.00 Multiply line 22 time line 23  5.97 21.00  22.00  22.00  23.00 0.00 22.00	20.00	Additional unweighted allemathic and esteemathic direct CME E	TE rosi dont	can slots roo	roi vod undor 42		20.00
21.00 Direct GME FTE unweighted resident count over cap (see instructions)  22.00 Allowable additional direct GME FTE Resident Count (see instructions)  23.00 Enter the locality adjustment national average per resident amount (see instructions)  24.00 Multiply line 22 time line 23  5.97 21.00  0.00 22.00  24.00 Multiply line 22 time line 23	∠∪. ∪∪	·	ir i esi delit	cap sidts rec	erveu under 42	0.00	20.00
23.00 Enter the locality adjustment national average per resident amount (see instructions)  0.00 23.00  Multiply line 22 time line 23		Direct GME FTE unweighted resident count over cap (see instru					
24.00 Multiply line 22 time line 23 0 24.00		1	,	netrueti one)			
		,	mount (See I	nati ucti (IIS)			

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der C	CN: 31-3300	Peri od:	Worksheet E-4	
EDI CA	L EDUCATION COSTS			From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 5:4	
		Titl∈	xVIII	Hospi tal	TEFRA	
				rt Managed Care	Total	
			1. 00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	0.00	
6. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part I)	X, line	2	29 0		26. 0
7 00	3. 02, col umn 2)		10.0	10 070		27.0
			19, 97			27. 0
8. 00 9. 00	Ratio of inpatient days to total inpatient days Program direct GME amount		0. 00145	0.000000	0	28. 0 29. 0
9. 00 9. 01	Percent reduction for MA DGME			3. 26	U	29.0
0.00	Reduction for direct GME payments for Medicare Advantage			3. 20	0	
	Net Program direct GME amount				0	
1. 00	net Frogram direct owe amount				J	31.0
					1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE EDUCATION COSTS)	XVIII ONLY	(NURSING PRO	OGRAM AND PARAMED	)I CAL	
2. 00	Renal dialysis direct medical education costs (from Wkst. B, F	Pt. I, sum c	of col. 20 and	1 23, lines 74	0	32.0
3. 00	and 94) Renal dialysis and home dialysis total charges (Wkst. C, Pt. I	l col 8 s	um of lines 7	74 and 94)	0	33.0
4. 00	Ratio of direct medical education costs to total charges (line			T dild 71)	0. 000000	
	Medicare outpatient ESRD charges (see instructions)	020	00)		0.00000	1
	Medicare outpatient ESRD direct medical education costs (line	34 x line 3	35)		0	36.0
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII		,			
	Part A Reasonable Cost					
7. 00	Reasonable cost (see instructions)				68, 030	
8. 00	Organ acquisition and HSCT acquisition costs (see instructions				0	1
9. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)			0	
	Primary payer payments (see instructions)	1.1 (0)			0	
1. 00	Total Part A reasonable cost (sum of lines 37 through 39 minus Part B Reasonable Cost	s line 40)			68, 030	41. (
2 00	Reasonable cost (see instructions)				44, 040	12 (
3. 00	Primary payer payments (see instructions)				14,040	
	Total Part B reasonable cost (line 42 minus line 43)				44, 040	
5. 00	Total reasonable cost (sum of lines 41 and 44)				112, 070	1
6. 00	Ratio of Part A reasonable cost to total reasonable cost (line	e 41 ÷ line	45)		0. 607031	
	Ratio of Part B reasonable cost to total reasonable cost (line				0. 392969	
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAR	RT B				
	Total program GME payment (line 31)			`	0	1
9. 00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)				0	1
0. 00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instru	ıcti ons)		0	50.0

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

Provider CCN: 31-3300

Peri od: Worksheet G From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/25/2023 5: 49 pm

37		General Fund	Speci fi c	Endowment Fund	<u>5/25/2023 5: 4</u>   Plant Fund	9 pm
		General Fund	Purpose Fund	Endownert Fund	Prant Fund	
	I	1.00	2.00	3. 00	4. 00	
1 00	CURRENT ASSETS	1 4/0 025		y al		1 00
1. 00 2. 00	Cash on hand in banks Temporary investments	1, 468, 035		-	0	
3.00	Notes receivable	0		-	0	
4. 00	Accounts receivable	23, 737, 896	Č	ol ol	0	
5.00	Other recei vabl e	83, 183, 721	C	o	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-5, 904, 095	C	0	0	
7. 00	Inventory	0	C	0	0	
8.00	Prepai d expenses	1, 337, 802	C	0	0	8. 00
9. 00 10. 00	Other current assets Due from other funds	11, 645, 111			0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	115, 468, 470		1 1	0	11.00
11.00	FI XED ASSETS	113, 400, 470		γ <u> </u>		11.00
12. 00	Land	1, 115, 616	C	0	0	12. 00
13.00	Land improvements	3, 485, 763	C	o	0	13. 00
14. 00	Accumulated depreciation	-2, 674, 832	C	-	0	14. 00
15. 00	Bui I di ngs	144, 269, 659	C	0	0	15. 00
16. 00	Accumulated depreciation	-45, 394, 820		0	0	16.00
17. 00 18. 00	Leasehold improvements Accumulated depreciation	16, 277, 251 -15, 457, 392	) (		0	17. 00 18. 00
19. 00	Fi xed equi pment	37, 973, 532			0	19.00
20. 00	Accumulated depreciation	-27, 059, 407	ď	ol ol	0	20.00
21. 00	Automobiles and trucks	0	d	o	0	21. 00
22. 00	Accumulated depreciation	0	C	o	0	22. 00
23. 00	Major movable equipment	65, 951, 501	C	0	0	23. 00
24. 00	Accumulated depreciation	-57, 092, 633	C	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	C	0	0	25. 00
26. 00	Accumulated depreciation	0			0	26.00
27. 00 28. 00	HIT designated Assets Accumulated depreciation	0			0	27. 00 28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0			0	29.00
30. 00	Total fixed assets (sum of lines 12-29)	121, 394, 238	_	-	0	30.00
	OTHER ASSETS	, , , , , , , , , , , , , , , , , , , ,		1		
31.00	Investments	0	C	0	0	31. 00
32. 00	Deposits on Leases	0	C	0	0	32. 00
33. 00	Due from owners/officers	0	C	0	0	33. 00
34. 00	Other assets	35, 618, 212		0	0	34. 00
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	35, 618, 212 272, 480, 920			0	35. 00 36. 00
30.00	CURRENT LIABILITIES	272, 400, 720		<u> </u>		30.00
37. 00	Accounts payable	4, 220, 580	C	ol	0	37. 00
38. 00	Sal ari es, wages, and fees payable	10, 980, 344	c	o	0	
39. 00	Payroll taxes payable	0	C	0	0	39. 00
40. 00	Notes and Loans payable (short term)	914, 794	C	0	0	40. 00
41. 00	Deferred income	0	C	이	0	41.00
42. 00	Accel erated payments	0 000 474	_		0	42.00
43. 00 44. 00	Due to other funds Other current liabilities	9, 002, 674			0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	25, 118, 392	C	o o		
10.00	LONG TERM LIABILITIES	2071107072		,		10.00
46.00	Mortgage payable	0	C	0	0	46. 00
47. 00	Notes payable	40, 822, 597	C	0	0	47. 00
48. 00	Unsecured Loans	0	C	-	0	1
49. 00	Other long term liabilities	40, 974, 327	C	-	0	
50.00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	81, 796, 924		-	0	50. 00 51. 00
51. 00	CAPITAL ACCOUNTS	106, 915, 316		)	0	51.00
52. 00	General fund balance	165, 565, 604				52. 00
53. 00	Specific purpose fund		c			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	165, 565, 604	,	ا ا	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	272, 480, 920			0	
	59)				· ·	
				·		

| Peri od: | Worksheet G-1 | From 01/01/2022 | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 31-3300

					To 12/31/20	22 Date/Time Pre 5/25/2023 5:4	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) NET TRANSFER OF EQUITY INT IN TRNA OF UNCONS FDN CONTRIBUTED CAPITAL CONTRIBUTED CAPITAL - UR  Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) INT IN PRNA OF UNCONS FDN CONTRIBUTED CAPITAL - RESTRICTED  Total deductions (sum of lines 12-17) Fund balance at end of period per balance	1, 041, 755 8, 193, 464 12, 465, 066 8, 813, 724 0 0 1, 150, 979 12, 465, 066 0 0	0 -3, 106, 508 -3, 106, 508 30, 514, 009 27, 407, 501 13, 616, 045 13, 791, 456		0 0 0 0 0 0 0		5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) NET TRANSFER OF EQUITY INT IN TRNA OF UNCONS FDN CONTRIBUTED CAPITAL CONTRIBUTED CAPITAL - UR	0	0 0 0 0 0	G. 66	0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Subtotal (line 3 plus line 10) INT IN PRNA OF UNCONS FDN CONTRIBUTED CAPITAL - RESTRICTED  Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0 0 0 0 0		0 0		11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

 
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 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES
 Provider CCN: 31-3300

			10 12/31/2022	5/25/2023 5:4				
	Cost Center Description	Inpatient	Outpati ent	Total	) piii			
		1.00	2. 00	3. 00				
	PART I - PATIENT REVENUES							
	General Inpatient Routine Services							
1.00	Hospi tal	169, 444, 85	3	169, 444, 858	1. 00			
2.00	SUBPROVI DER - I PF				2. 00			
3.00	SUBPROVI DER - I RF				3. 00			
4.00	SUBPROVI DER				4. 00			
5.00	Swing bed - SNF		O	0	5. 00			
6.00	Swing bed - NF		)	0	6. 00			
7.00	SKILLED NURSING FACILITY		D	0	7. 00			
8.00	NURSING FACILITY		O	0	8. 00			
9.00	OTHER LONG TERM CARE				9. 00			
10.00	Total general inpatient care services (sum of lines 1-9)	169, 444, 85	3	169, 444, 858	10. 00			
	Intensive Care Type Inpatient Hospital Services							
11. 00	INTENSIVE CARE UNIT				11. 00			
12. 00	CORONARY CARE UNIT				12. 00			
13. 00	BURN INTENSIVE CARE UNIT				13. 00			
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00			
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00			
16. 00	Total intensive care type inpatient hospital services (sum of lines	1	D	0	16. 00			
	11-15)							
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	169, 444, 85		169, 444, 858				
18. 00	Ancillary services		102, 710, 145		18.00			
19.00	Outpati ent servi ces		0		19. 00			
20.00	RURAL HEALTH CLINIC		0		20.00			
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	'	0	0	21. 00			
22. 00	HOME HEALTH AGENCY				22. 00			
23. 00	AMBULANCE SERVICES				23. 00			
24. 00 25. 00	CMHC				24. 00 25. 00			
26. 00	AMBULATORY SURGI CAL CENTER (D. P. ) HOSPI CE				26. 00			
27. 00	OTHER (SPECIFY)		0	o	27. 00			
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst	169, 444, 85	3 102, 710, 145					
20.00	G-3, line 1)	107, 444, 65	102, 710, 143	272, 155, 005	20.00			
	PART II - OPERATING EXPENSES							
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		177, 307, 547		29. 00			
30. 00	ADD (SPECIFY)		)		30.00			
31. 00	()				31. 00			
32. 00					32. 00			
33. 00			D		33. 00			
34.00			o		34.00			
35.00			)		35. 00			
36.00	Total additions (sum of lines 30-35)		0		36. 00			
37.00	DEDUCT (SPECIFY)		O		37. 00			
38. 00			D		38. 00			
39. 00			D		39. 00			
40.00			D		40. 00			
41. 00			O		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)(trans	sfer	177, 307, 547		43. 00			
	to Wkst. G-3, line 4)							

Health Financial Systems CHILDRENS SPECIALIZED HOPSITAL In Lieu of Form CMS-2552								
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 31-3300 Period:			Worksheet G-3					
				From 01/01/2022 To 12/31/2022	Date/Time Prep 5/25/2023 5:49			
	1 00	T			1.00	4 00		
	1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28	3)		272, 155, 003			
	2.00	Less contractual allowances and discounts on patients' accounts	122, 014, 070					
	3.00	Net patient revenues (line 1 minus line 2)	150, 140, 933 177, 307, 547					
	4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)						
	5.00	Net income from service to patients (line 3 minus line 4)	-27, 166, 614	5. 00				
		OTHER I NCOME			0	,		
	6.00	Contributions, donations, bequests, etc				6. 00		
	7.00	Income from investments				7. 00		
	8.00	Revenues from telephone and other miscellaneous communication ser	0	8. 00				
	9.00	Revenue from television and radio service	0	9. 00				
						10. 00		
		Rebates and refunds of expenses	0	11. 00				
		Parking Lot receipts	0	12.00				
		Revenue from Laundry and Linen service			0	13.00		
		Revenue from meals sold to employees and guests			120, 940			
		Revenue from rental of living quarters			0	15. 00		
		Revenue from sale of medical and surgical supplies to other than patients				16. 00		
		Revenue from sale of drugs to other than patients	0	17. 00				
		Revenue from sale of medical records and abstracts			52, 931			
		Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00		
		Revenue from gifts, flowers, coffee shops, and canteen			0	20.00		
	21. 00	Rental of vending machines			13, 244	21.00		
	22. 00	Rental of hospital space			0	22. 00		

0 23.00

24.00

24. 01

24.02

24.03

24.04

24. 05

24.06

24.07

24.08

24. 50

25.00

26.00

0 28.00 -3, 106, 508 29.00

98, 423

9, 275

1, 850, 958

5, 806, 792

1, 235, 899

14, 235, 390

24, 060, 106

-3, 106, 508

300, 537

329, 364

6, 353

0

0 27.00

23.00 Governmental appropriations

24.00 FEDERAL STIMULUS REVENUE

PURCHASE DI SCOUNTS

OTHER MI SCELLANEOUS

24. 04 FOUND - NET ASSETS RELEASED

24. 05 INTEREST INCOME - OPERATIONS 24. 06 GRANTS - FEDERAL AND STATE

COVI D-19 PHE Funding

26.00 Total (line 5 plus line 25)

27. 00 OTHER EXPENSES (SPECIFY)

RADY CHRONIC PAIN PRG REVENUE

Total other income (sum of lines 6-24)

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

24. 03 RENTAL INCOME

24. 08 FEMA C-19

24. 01

24.02

24.07

24. 50

25.00