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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1309	Period: From 07/01/2022 To 06/30/2023	Worksheet S Parts I-III Date/Time Prepared: 11/22/2023 1:19 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/22/2023 Time: 1:19 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ASCENSION ST. VINCENT CLAY (15-1309) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Chris Hons		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Chris Hons			2
3	Signatory Title	VP OF FINANCE			3
4	Date	11/22/2023 01:19:10 PM			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-177,841	-507,363	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	-69,992	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	-247,833	-507,363	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/22/2023 1:19 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1206 EAST NATIONAL AVENUE	PO Box:			1.00
2.00	City: BRAZIL	State: IN	Zip Code: 47834	County: CLAY	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ASCENSION ST. VINCENT CLAY	151309	45460	1	08/08/2001	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ASCENSION ST. VINCENT CLAY SWING	15Z309	45460		08/08/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2022	06/30/2023	20.00
21.00	Type of Control (see instructions)	1		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2023 1:19 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1309	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 11/22/2023 1:19 pm

		V	XVIII	XIX	
		1.00	2.00	3.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/22/2023 1:19 pm

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/(col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/(col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/(col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1309	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 11/22/2023 1:19 pm

					1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)					
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?				N	68.00
			1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00
					1.00	
	Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N	81.00
	TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.				N	87.00
				Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
				1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.			N	0	88.00
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
			1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.		0.00		0	89.00
				V	XIX	
				1.00	2.00	
	Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				Y	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/22/2023 1:19 pm

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/22/2023 1:19 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	127,265	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H046	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ASCENSION ST. VINCENT	Contractor's Name: WPS	Contractor's Number: 08001	141.00
142.00	Street: 250 WEST 96TH STREET SUITE 215	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46260	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1309	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 11/22/2023 1:19 pm

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/22/2023 1:19 pm

			Y/N	Date	
			1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE				
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/06/2023	Y	10/06/2023	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
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/22/2023 1:19 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL	HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ASCENSION		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(317) 583-3519	JILL.HILL1@ASCENSION.ORG	43.00

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 11/22/2023 1:19 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	15,000.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	15,000.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	15,000.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/22/2023 1:19 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	294	13	625			1.00
2.00	HMO and other (see instructions)	177	59				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	102	0	174			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	396	13	799			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	0	0	0			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)	396	13	799	0.00	48.96	14.00
15.00	CAH visits	7,515	590	31,688			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	48.96	27.00
28.00	Observation Bed Days		0	651			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/22/2023 1:19 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	77	7	165	1.00
2.00	HMO and other (see instructions)			32	20		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	77	7	165	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-10 | Date/Time Prepared: 11/22/2023 1:19 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.264144	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,724,110	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	19,407,797	6.00
7.00	Medicaid cost (line 1 times line 6)	5,126,453	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	3,402,343	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,402,343	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	857,579	446,030	1,303,609	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	226,524	446,030	672,554	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	226,524	446,030	672,554	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,828,764	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	294,654	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	453,314	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,375,450	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	521,977	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,194,531	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,596,874	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/22/2023 1:19 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		453,149	453,149	0	453,149	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		411,687	411,687	0	411,687	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	139,119	1,099,182	1,238,301	0	1,238,301	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	397,457	6,655,234	7,052,691	-11,781	7,040,910	5.00
7.00	00700	OPERATION OF PLANT	0	1,137,852	1,137,852	0	1,137,852	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	50,760	50,760	0	50,760	8.00
9.00	00900	HOUSEKEEPING	0	428,887	428,887	0	428,887	9.00
10.00	01000	DIETARY	0	521,628	521,628	-447,845	73,783	10.00
11.00	01100	CAFETERIA	0	0	0	447,845	447,845	11.00
13.00	01300	NURSING ADMINISTRATION	92,824	45,555	138,379	0	138,379	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,495	-11,781	-286	11,781	11,495	14.00
15.00	01500	PHARMACY	237,485	317,276	554,761	0	554,761	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	968,354	212,078	1,180,432	-236	1,180,196	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	376,363	198,409	574,772	-66,278	508,494	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	962,693	225,440	1,188,133	0	1,188,133	54.00
60.00	06000	LABORATORY	34,374	1,642,496	1,676,870	0	1,676,870	60.00
65.00	06500	RESPIRATORY THERAPY	179,456	15,023	194,479	0	194,479	65.00
66.00	06600	PHYSICAL THERAPY	0	925,639	925,639	-122,978	802,661	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	120,746	120,746	67.00
68.00	06800	SPEECH PATHOLOGY	0	135,910	135,910	0	135,910	68.00
69.00	06900	ELECTROCARDIOLOGY	105,285	8,000	113,285	0	113,285	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	38,041	38,041	74,808	112,849	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	127,386	127,386	0	127,386	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	962,735	1,222,264	2,184,999	-6,062	2,178,937	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,467,640	15,860,115	20,327,755	0	20,327,755	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	36,191	36,191	0	36,191	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MISSION SERVICES	0	0	0	0	0	193.01
200.00		TOTAL (SUM OF LINES 118 through 199)	4,467,640	15,896,306	20,363,946	0	20,363,946	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/22/2023 1:19 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	70,107	523,256		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	411,687		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	10,033	1,248,334		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,429,164	4,611,746		5.00
7.00	00700	OPERATION OF PLANT	0	1,137,852		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	50,760		8.00
9.00	00900	HOUSEKEEPING	0	428,887		9.00
10.00	01000	DIETARY	0	73,783		10.00
11.00	01100	CAFETERIA	-31,175	416,670		11.00
13.00	01300	NURSING ADMINISTRATION	-9,090	129,289		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,495		14.00
15.00	01500	PHARMACY	0	554,761		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,180,196		30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0		33.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-21,055	487,439		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-57,726	1,130,407		54.00
60.00	06000	LABORATORY	0	1,676,870		60.00
65.00	06500	RESPIRATORY THERAPY	0	194,479		65.00
66.00	06600	PHYSICAL THERAPY	0	802,661		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	120,746		67.00
68.00	06800	SPEECH PATHOLOGY	0	135,910		68.00
69.00	06900	ELECTROCARDIOLOGY	0	113,285		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-37,271	75,578		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	127,386		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	2,178,937		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,505,341	17,822,414		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	36,191		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	MISSION SERVICES	0	0		193.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,505,341	17,858,605		200.00

RECLASSIFICATIONS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/22/2023 1:19 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	0	447,845		1.00
	TOTALS		0	447,845		
	B - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		74,808		1.00
2.00						2.00
3.00						3.00
4.00						4.00
			0	74,808		
	C - OCCUPATIONAL THERAPY					
1.00	OCCUPATIONAL THERAPY	67.00		120,746		1.00
			0	120,746		
	D - CENTRAL SERVICES & SUPPLY					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	11,781		1.00
	TOTALS		0	11,781		
500.00	Grand Total: Increases		0	655,180		500.00

RECLASSIFICATIONS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/22/2023 1:19 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	0	447,845	0		1.00
	TOTALS		0	447,845			
	B - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00		236			1.00
2.00	OPERATING ROOM	50.00		66,278			2.00
3.00	PHYSICAL THERAPY	66.00		2,232			3.00
4.00	EMERGENCY	91.00		6,062			4.00
			0	74,808			
	C - OCCUPATIONAL THERAPY						
1.00	PHYSICAL THERAPY	66.00		120,746			1.00
			0	120,746			
	D - CENTRAL SERVICES & SUPPLY						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11,781	0		1.00
	TOTALS		0	11,781			
500.00	Grand Total: Decreases		0	655,180			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part I Date/Time Prepared: 11/22/2023 1:19 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,500	0	0	0	0	1.00
2.00	Land Improvements	621,527	0	0	0	0	2.00
3.00	Buildings and Fixtures	11,059,119	653,351	0	653,351	0	3.00
4.00	Building Improvements	995,041	0	0	0	0	4.00
5.00	Fixed Equipment	3,131,335	289,915	0	289,915	0	5.00
6.00	Movable Equipment	8,092,094	0	0	0	827,136	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	23,901,616	943,266	0	943,266	827,136	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	23,901,616	943,266	0	943,266	827,136	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,500	0	1.00
2.00	Land Improvements	621,527	0	2.00
3.00	Buildings and Fixtures	11,712,470	0	3.00
4.00	Building Improvements	995,041	0	4.00
5.00	Fixed Equipment	3,421,250	0	5.00
6.00	Movable Equipment	7,264,958	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,017,746	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	24,017,746	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part II Date/Time Prepared: 11/22/2023 1:19 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	453,149	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	375,152	36,535	0	0	0	2.00
3.00	Total (sum of lines 1-2)	828,301	36,535	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	453,149	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	411,687	2.00
3.00	Total (sum of lines 1-2)	0	864,836	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 11/22/2023 1:19 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	13,331,538	0	13,331,538	0.555070	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,686,208	0	10,686,208	0.444930	0	2.00
3.00	Total (sum of lines 1-2)	24,017,746	0	24,017,746	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	453,149	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	375,152	36,535	2.00
3.00	Total (sum of lines 1-2)	0	0	0	828,301	36,535	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	70,107	0	0	0	523,256	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	411,687	2.00
3.00	Total (sum of lines 1-2)	70,107	0	0	0	934,943	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/22/2023 1:19 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-196,564	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-8,110	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-78,781			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	622,747			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-31,175	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	Admin Revenue	B	-2,000	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/22/2023 1:19 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	ENTERTAINMENT	A	-1,173	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.03	LOBBYING	A	-510	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	DONATIONS	A	-4,417	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.06	PROVIDER TAX	A	-1,486,288	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.08	Physician Fund Expense	A	-1,246,403	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	Physician Fund Expense	A	-72,667	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,505,341				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
  A. Costs - if cost, including applicable overhead, can be determined.
  B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 11/22/2023 1:19 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - CAPITAL	235,737	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - INTEREST - Cap	8,754	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - INTEREST - A&G	72	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - OTHER	2,906,248	2,493,807	3.01
3.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	1,416	1,416	3.02
3.03	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACKS	5,664	5,664	3.03
3.04	69.00	ELECTROCARDIOLOGY	SVH CHARGEBACKS	7,000	7,000	3.04
3.05	91.00	EMERGENCY	SVH CHARGEBACKS	4,500	4,500	3.05
3.07	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	654,607	571,907	3.07
3.08	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	266,671	0	3.08
3.09	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	2,177	268,575	3.09
3.10	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE - TRG - SUPPLIES	-37,271	0	3.10
3.11	13.00	NURSING ADMINISTRATION	HOME OFFICE - TRG - CONTRACT	-9,090	0	3.11
3.12	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - TRG - ALL OTHE	-70,869	0	3.12
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,975,616	3,352,869	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1309	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-1 Date/Time Prepared: 11/22/2023 1:19 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	235,737	0		1.00
2.00	8,754	0		2.00
3.00	72	0		3.00
3.01	412,441	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
3.07	82,700	0		3.07
3.08	266,671	11		3.08
3.09	-266,398	0		3.09
3.10	-37,271	0		3.10
3.11	-9,090	0		3.11
3.12	-70,869	0		3.12
4.00	0	0		4.00
5.00	622,747			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00	Administration		6.00
7.00	Administration		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 11/22/2023 1:19 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	21,055	21,055	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	57,726	57,726	0	0	0	2.00
3.00	91.00	EMERGENCY	1,018,913	0	1,018,913	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,097,694	78,781	1,018,913		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	OPERATING ROOM	0	0	0	21,055		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	57,726		2.00
3.00	91.00	EMERGENCY	0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	78,781		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/22/2023 1:19 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					51	1.00
2.00	Line 1 multiplied by 15 hours per week					765	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					290	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					12	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					9.57	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	1,877.00	3,507.00	5,575.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	110.02	95.67	62.19	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	47.84	47.84	31.10			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					206,508	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					335,515	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					346,709	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					888,732	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					888,732	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					888,732	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					13,874	24.00
25.00	Assistants (line 4 times column 3, line 11)					373	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					14,247	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					2,890	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					17,137	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					17,137	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/22/2023 1:19 pm

Physical Therapy | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	95.67	62.19	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	888,732		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	17,137		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	905,869		63.00
64.00	Total cost of outside supplier services (from your records)	783,892		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	14,247		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,890		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	17,137		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,890		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	2,890		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/22/2023 1:19 pm

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		49	1.00
2.00	Line 1 multiplied by 15 hours per week		735	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		224	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		9.57	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,688.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	90.69	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	45.35	45.35	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	153,085	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	153,085	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	153,085	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	153,085	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	10,158	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	10,158	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	2,144	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	12,302	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	12,302	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/22/2023 1:19 pm

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	90.69	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	153,085	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	12,302	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	165,387	63.00
64.00	Total cost of outside supplier services (from your records)	120,746	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	10,158	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,144	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	12,302	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,144	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	2,144	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/22/2023 1:19 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					195	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					9.57	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,593.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	87.17	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	43.59	43.59	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					138,862	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					138,862	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					138,862	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					138,862	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					8,500	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					8,500	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,866	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					10,366	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					10,366	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/22/2023 1:19 pm

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	87.17	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	138,862	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	10,366	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	149,228	63.00
64.00	Total cost of outside supplier services (from your records)	135,910	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	8,500	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,866	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	10,366	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,866	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,866	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/22/2023 1:19 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	523,256	523,256				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	411,687		411,687			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,248,334	0	0	1,248,334		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,611,746	195,387	153,729	114,625	5,075,487	5.00
7.00	00700	OPERATION OF PLANT	1,137,852	107,382	84,486	0	1,329,720	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	50,760	11,224	8,830	0	70,814	8.00
9.00	00900	HOUSEKEEPING	428,887	6,224	4,897	0	440,008	9.00
10.00	01000	DIETARY	73,783	13,825	10,877	0	98,485	10.00
11.00	01100	CAFETERIA	416,670	7,842	6,170	0	430,682	11.00
13.00	01300	NURSING ADMINISTRATION	129,289	12,251	9,639	26,770	177,949	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,495	0	0	3,315	14,810	14.00
15.00	01500	PHARMACY	554,761	6,142	4,832	68,490	634,225	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	54,449	42,839	0	97,288	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,180,196	35,346	27,809	279,272	1,522,623	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	487,439	14,510	11,416	108,542	621,907	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,130,407	10,062	7,917	277,638	1,426,024	54.00
60.00	06000	LABORATORY	1,676,870	8,229	6,474	9,913	1,701,486	60.00
65.00	06500	RESPIRATORY THERAPY	194,479	9,923	7,807	51,755	263,964	65.00
66.00	06600	PHYSICAL THERAPY	802,661	0	0	0	802,661	66.00
67.00	06700	OCCUPATIONAL THERAPY	120,746	0	0	0	120,746	67.00
68.00	06800	SPEECH PATHOLOGY	135,910	0	0	0	135,910	68.00
69.00	06900	ELECTROCARDIOLOGY	113,285	0	0	30,364	143,649	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	75,578	0	0	0	75,578	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	127,386	0	0	0	127,386	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,178,937	29,115	22,907	277,650	2,508,609	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,822,414	521,911	410,629	1,248,334	17,820,011	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,345	1,058	0	2,403	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	36,191	0	0	0	36,191	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MISSION SERVICES	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,858,605	523,256	411,687	1,248,334	17,858,605	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/22/2023 1:19 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,075,487					5.00
7.00	00700	OPERATION OF PLANT	527,960	1,857,680				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,116	82,442	181,372			8.00
9.00	00900	HOUSEKEEPING	174,703	45,718	0	660,429		9.00
10.00	01000	DIETARY	39,103	101,550	0	0	239,138	10.00
11.00	01100	CAFETERIA	171,001	57,602	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	70,654	89,992	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,880	0	0	0	0	14.00
15.00	01500	PHARMACY	251,816	45,113	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	38,628	399,955	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	604,551	259,631	181,372	154,503	239,138	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	246,926	106,583	0	87,027	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	566,197	155,704	0	58,430	0	54.00
60.00	06000	LABORATORY	675,568	60,445	0	46,519	0	60.00
65.00	06500	RESPIRATORY THERAPY	104,806	72,889	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	318,693	156,310	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	47,942	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	53,963	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	57,035	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,008	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	50,578	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	996,036	213,866	0	219,563	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,060,164	1,847,800	181,372	566,042	239,138	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	954	9,880	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,369	0	0	94,387	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MISSION SERVICES	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,075,487	1,857,680	181,372	660,429	239,138	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/22/2023 1:19 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	659,285					11.00
13.00	01300	NURSING ADMINISTRATION	11,981	350,576				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,626	0	24,316			14.00
15.00	01500	PHARMACY	32,476	0	0	963,630		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	535,871	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	162,063	161,652	0	0	26,645	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	70,153	42,721	0	0	48,915	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	157,806	0	0	0	142,922	54.00
60.00	06000	LABORATORY	16,080	236	0	0	99,965	60.00
65.00	06500	RESPIRATORY THERAPY	32,633	0	0	0	8,599	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	28,863	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	6,297	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	3,278	68.00
69.00	06900	ELECTROCARDIOLOGY	24,435	15,572	0	0	21,893	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	24,316	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	963,630	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	148,032	130,395	0	0	148,494	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	659,285	350,576	24,316	963,630	535,871	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MISSION SERVICES	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	659,285	350,576	24,316	963,630	535,871	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/22/2023 1:19 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,312,178	0	3,312,178		30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0		33.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,224,232	0	1,224,232		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,507,083	0	2,507,083		54.00
60.00	06000	LABORATORY	2,600,299	0	2,600,299		60.00
65.00	06500	RESPIRATORY THERAPY	482,891	0	482,891		65.00
66.00	06600	PHYSICAL THERAPY	1,306,527	0	1,306,527		66.00
67.00	06700	OCCUPATIONAL THERAPY	174,985	0	174,985		67.00
68.00	06800	SPEECH PATHOLOGY	193,151	0	193,151		68.00
69.00	06900	ELECTROCARDIOLOGY	262,584	0	262,584		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,902	0	129,902		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	177,964	0	177,964		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	963,630	0	963,630		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	4,364,995	0	4,364,995		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,700,421	0	17,700,421		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,237	0	13,237		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	144,947	0	144,947		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	MISSION SERVICES	0	0	0		193.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	17,858,605	0	17,858,605		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/22/2023 1:19 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	511,539	195,387	153,729	860,655	0	5.00
7.00	00700	OPERATION OF PLANT	0	107,382	84,486	191,868	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,224	8,830	20,054	0	8.00
9.00	00900	HOUSEKEEPING	0	6,224	4,897	11,121	0	9.00
10.00	01000	DIETARY	0	13,825	10,877	24,702	0	10.00
11.00	01100	CAFETERIA	0	7,842	6,170	14,012	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	12,251	9,639	21,890	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	6,142	4,832	10,974	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	54,449	42,839	97,288	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	35,346	27,809	63,155	0	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,510	11,416	25,926	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,062	7,917	17,979	0	54.00
60.00	06000	LABORATORY	0	8,229	6,474	14,703	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,923	7,807	17,730	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	29,115	22,907	52,022	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	511,539	521,911	410,629	1,444,079	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,345	1,058	2,403	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MISSION SERVICES	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	511,539	523,256	411,687	1,446,482	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/22/2023 1:19 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	860,655					5.00
7.00	00700	OPERATION OF PLANT	89,526	281,394				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,768	12,488	37,310			8.00
9.00	00900	HOUSEKEEPING	29,624	6,925	0	47,670		9.00
10.00	01000	DIETARY	6,631	15,382	0	0	46,715	10.00
11.00	01100	CAFETERIA	28,997	8,725	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	11,981	13,632	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	997	0	0	0	0	14.00
15.00	01500	PHARMACY	42,700	6,833	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,550	60,585	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	102,514	39,328	37,310	11,152	46,715	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	41,871	16,145	0	6,282	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	96,010	23,585	0	4,218	0	54.00
60.00	06000	LABORATORY	114,556	9,156	0	3,358	0	60.00
65.00	06500	RESPIRATORY THERAPY	17,772	11,041	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	54,041	23,677	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,129	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,150	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	9,671	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,088	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,577	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	168,903	32,395	0	15,847	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	858,056	279,897	37,310	40,857	46,715	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	162	1,497	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,437	0	0	6,813	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MISSION SERVICES	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	860,655	281,394	37,310	47,670	46,715	202.00

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		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	51,734					11.00
13.00	01300	NURSING ADMINISTRATION	940	48,443				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	285	0	1,282			14.00
15.00	01500	PHARMACY	2,548	0	0	63,055		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	164,423	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,717	22,337	0	0	8,175	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,505	5,903	0	0	15,007	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,383	0	0	0	43,848	54.00
60.00	06000	LABORATORY	1,262	33	0	0	30,669	60.00
65.00	06500	RESPIRATORY THERAPY	2,561	0	0	0	2,638	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	8,855	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,932	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,006	68.00
69.00	06900	ELECTROCARDIOLOGY	1,917	2,152	0	0	6,717	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,282	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	63,055	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	11,616	18,018	0	0	45,576	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51,734	48,443	1,282	63,055	164,423	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MISSION SERVICES	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	51,734	48,443	1,282	63,055	164,423	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/22/2023 1:19 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	343,403	0	343,403		30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0		33.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	116,639	0	116,639		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	198,023	0	198,023		54.00
60.00	06000	LABORATORY	173,737	0	173,737		60.00
65.00	06500	RESPIRATORY THERAPY	51,742	0	51,742		65.00
66.00	06600	PHYSICAL THERAPY	86,573	0	86,573		66.00
67.00	06700	OCCUPATIONAL THERAPY	10,061	0	10,061		67.00
68.00	06800	SPEECH PATHOLOGY	10,156	0	10,156		68.00
69.00	06900	ELECTROCARDIOLOGY	20,457	0	20,457		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,370	0	6,370		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,577	0	8,577		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	63,055	0	63,055		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	344,377	0	344,377		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,433,170	0	1,433,170		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,062	0	4,062		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,250	0	9,250		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	MISSION SERVICES	0	0	0		193.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,446,482	0	1,446,482		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/22/2023 1:19 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	82,473					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		82,473				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	4,328,521			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,796	30,796	397,457	-5,075,487	12,783,118	5.00
7.00	00700	OPERATION OF PLANT	16,925	16,925	0	0	1,329,720	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,769	1,769	0	0	70,814	8.00
9.00	00900	HOUSEKEEPING	981	981	0	0	440,008	9.00
10.00	01000	DIETARY	2,179	2,179	0	0	98,485	10.00
11.00	01100	CAFETERIA	1,236	1,236	0	0	430,682	11.00
13.00	01300	NURSING ADMINISTRATION	1,931	1,931	92,824	0	177,949	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	11,495	0	14,810	14.00
15.00	01500	PHARMACY	968	968	237,485	0	634,225	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,582	8,582	0	0	97,288	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,571	5,571	968,354	0	1,522,623	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,287	2,287	376,363	0	621,907	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,586	1,586	962,693	0	1,426,024	54.00
60.00	06000	LABORATORY	1,297	1,297	34,374	0	1,701,486	60.00
65.00	06500	RESPIRATORY THERAPY	1,564	1,564	179,456	0	263,964	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	802,661	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	120,746	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	135,910	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	105,285	0	143,649	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	75,578	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	127,386	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,589	4,589	962,735	0	2,508,609	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	82,261	82,261	4,328,521	-5,075,487	12,744,524	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	212	212	0	0	2,403	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	36,191	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MISSION SERVICES	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	523,256	411,687	1,248,334		5,075,487	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.344573	4.991779	0.288397		0.397046	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		860,655	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.067327	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/22/2023 1:19 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	39,861					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,769	625				8.00
9.00	00900	HOUSEKEEPING	981	0	11,755			9.00
10.00	01000	DIETARY	2,179	0	0	100		10.00
11.00	01100	CAFETERIA	1,236	0	0	0	4,182	11.00
13.00	01300	NURSING ADMINISTRATION	1,931	0	0	0	76	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	23	14.00
15.00	01500	PHARMACY	968	0	0	0	206	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,582	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,571	625	2,750	100	1,028	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,287	0	1,549	0	445	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,341	0	1,040	0	1,001	54.00
60.00	06000	LABORATORY	1,297	0	828	0	102	60.00
65.00	06500	RESPIRATORY THERAPY	1,564	0	0	0	207	65.00
66.00	06600	PHYSICAL THERAPY	3,354	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	155	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,589	0	3,908	0	939	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,649	625	10,075	100	4,182	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	212	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,680	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MISSION SERVICES	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,857,680	181,372	660,429	239,138	659,285	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	46.603949	290.195200	56.182816	2,391.380000	157.648254	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	281,394	37,310	47,670	46,715	51,734	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.059381	59.696000	4.055296	467.150000	12.370636	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/22/2023 1:19 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	50,451					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	100				14.00
15.00	01500	PHARMACY	0	0	1,000			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	62,464,958		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,263	0	0	3,105,859		30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0		33.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,148	0	0	5,701,709		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,659,516		54.00
60.00	06000	LABORATORY	34	0	0	11,652,345		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,002,374		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,364,347		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	734,006		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	382,080		68.00
69.00	06900	ELECTROCARDIOLOGY	2,241	0	0	2,551,943		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	100	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,000	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	18,765	0	0	17,310,779		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,451	100	1,000	62,464,958		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	MISSION SERVICES	0	0	0	0		193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	350,576	24,316	963,630	535,871		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.948841	243.160000	963.630000	0.008579		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	48,443	1,282	63,055	164,423		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.960199	12.820000	63.055000	0.002632		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/22/2023 1:19 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,312,178		3,312,178	0	0	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,224,232		1,224,232	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,507,083		2,507,083	0	0	54.00
60.00	06000	LABORATORY	2,600,299		2,600,299	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	482,891	0	482,891	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,306,527	0	1,306,527	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	174,985	0	174,985	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	193,151	0	193,151	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	262,584		262,584	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,902		129,902	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	177,964		177,964	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	963,630		963,630	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,364,995		4,364,995	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,487,053		1,487,053		0	92.00
200.00		Subtotal (see instructions)	19,187,474	0	19,187,474	0	0	200.00
201.00		Less Observation Beds	1,487,053		1,487,053		0	201.00
202.00		Total (see instructions)	17,700,421	0	17,700,421	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/22/2023 1:19 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,577,765		1,577,765			30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0			33.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	221,952	5,479,757	5,701,709	0.214713	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	215,174	16,444,343	16,659,517	0.150490	0.000000	54.00
60.00	06000	LABORATORY	433,371	11,218,974	11,652,345	0.223157	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	445,984	556,390	1,002,374	0.481747	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	182,080	3,182,267	3,364,347	0.388345	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	72,662	661,344	734,006	0.238397	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	5,790	376,290	382,080	0.505525	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	37,524	2,514,420	2,551,944	0.102896	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	151,691	698,502	850,193	0.152791	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	79,939	332,855	412,794	0.431121	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	394,268	2,888,220	3,282,488	0.293567	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	123,103	17,187,676	17,310,779	0.252155	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	89,948	1,438,146	1,528,094	0.973142	0.000000	92.00
200.00		Subtotal (see instructions)	4,031,251	62,979,184	67,010,435			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,031,251	62,979,184	67,010,435			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/22/2023 1:19 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS			30.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/22/2023 1:19 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,312,178		3,312,178	0	3,312,178	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,224,232		1,224,232	0	1,224,232	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,507,083		2,507,083	0	2,507,083	54.00
60.00	06000	LABORATORY	2,600,299		2,600,299	0	2,600,299	60.00
65.00	06500	RESPIRATORY THERAPY	482,891	0	482,891	0	482,891	65.00
66.00	06600	PHYSICAL THERAPY	1,306,527	0	1,306,527	0	1,306,527	66.00
67.00	06700	OCCUPATIONAL THERAPY	174,985	0	174,985	0	174,985	67.00
68.00	06800	SPEECH PATHOLOGY	193,151	0	193,151	0	193,151	68.00
69.00	06900	ELECTROCARDIOLOGY	262,584		262,584	0	262,584	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,902		129,902	0	129,902	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	177,964		177,964	0	177,964	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	963,630		963,630	0	963,630	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,364,995		4,364,995	0	4,364,995	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,487,053		1,487,053		1,487,053	92.00
200.00		Subtotal (see instructions)	19,187,474	0	19,187,474	0	19,187,474	200.00
201.00		Less Observation Beds	1,487,053		1,487,053		1,487,053	201.00
202.00		Total (see instructions)	17,700,421	0	17,700,421	0	17,700,421	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/22/2023 1:19 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,577,765		1,577,765			30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0			33.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	221,952	5,479,757	5,701,709	0.214713	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	215,174	16,444,343	16,659,517	0.150490	0.000000	54.00
60.00	06000	LABORATORY	433,371	11,218,974	11,652,345	0.223157	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	445,984	556,390	1,002,374	0.481747	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	182,080	3,182,267	3,364,347	0.388345	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	72,662	661,344	734,006	0.238397	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	5,790	376,290	382,080	0.505525	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	37,524	2,514,420	2,551,944	0.102896	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	151,691	698,502	850,193	0.152791	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	79,939	332,855	412,794	0.431121	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	394,268	2,888,220	3,282,488	0.293567	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	123,103	17,187,676	17,310,779	0.252155	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	89,948	1,438,146	1,528,094	0.973142	0.000000	92.00
200.00		Subtotal (see instructions)	4,031,251	62,979,184	67,010,435			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,031,251	62,979,184	67,010,435			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/22/2023 1:19 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS			30.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 11/22/2023 1:19 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	116,639	5,701,709	0.020457	31,666	648	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	198,023	16,659,517	0.011886	63,324	753	54.00
60.00	06000	LABORATORY	173,737	11,652,345	0.014910	146,291	2,181	60.00
65.00	06500	RESPIRATORY THERAPY	51,742	1,002,374	0.051619	192,908	9,958	65.00
66.00	06600	PHYSICAL THERAPY	86,573	3,364,347	0.025732	52,286	1,345	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,061	734,006	0.013707	23,466	322	67.00
68.00	06800	SPEECH PATHOLOGY	10,156	382,080	0.026581	2,858	76	68.00
69.00	06900	ELECTROCARDIOLOGY	20,457	2,551,944	0.008016	2,732	22	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,370	850,193	0.007492	65,167	488	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,577	412,794	0.020778	10,732	223	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	63,055	3,282,488	0.019210	146,950	2,823	73.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	344,377	17,310,779	0.019894	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	154,176	1,528,094	0.100894	2,229	225	92.00
200.00		Total (lines 50 through 199)	1,243,943	65,432,670		740,609	19,064	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/22/2023 1:19 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/22/2023 1:19 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	5,701,709	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,659,517	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	11,652,345	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,002,374	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,364,347	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	734,006	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	382,080	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,551,944	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	850,193	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	412,794	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,282,488	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	17,310,779	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,528,094	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	65,432,670		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/22/2023 1:19 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	31,666	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	63,324	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	146,291	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	192,908	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	52,286	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	23,466	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,858	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,732	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	65,167	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	10,732	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	146,950	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2,229	0	0	0	92.00
200.00		Total (lines 50 through 199)		740,609	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/22/2023 1:19 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.214713	0	1,348,530	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150490	0	4,041,662	0	0	54.00
60.00	06000	LABORATORY	0.223157	0	2,826,810	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.481747	0	180,447	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.388345	0	959,172	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.238397	0	169,713	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.505525	0	47,486	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.102896	0	277,191	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152791	0	186,613	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.431121	0	58,346	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293567	0	899,048	2,301	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.252155	0	2,404,936	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.973142	0	460,588	0	0	92.00
200.00		Subtotal (see instructions)		0	13,860,542	2,301	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	13,860,542	2,301	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/22/2023 1:19 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	289,547	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	608,230	0		54.00
60.00	06000	LABORATORY	630,822	0		60.00
65.00	06500	RESPIRATORY THERAPY	86,930	0		65.00
66.00	06600	PHYSICAL THERAPY	372,490	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	40,459	0		67.00
68.00	06800	SPEECH PATHOLOGY	24,005	0		68.00
69.00	06900	ELECTROCARDIOLOGY	28,522	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,513	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,154	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	263,931	675		73.00
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	606,417	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	448,218	0		92.00
200.00		Subtotal (see instructions)	3,453,238	675		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,453,238	675		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1309 | Component CCN: 15-Z309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/22/2023 1:19 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.214713	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150490	0	0	0	0	54.00
60.00	06000	LABORATORY	0.223157	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.481747	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.388345	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.238397	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.505525	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.102896	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152791	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.431121	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293567	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.252155	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.973142	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1309 | Component CCN: 15-Z309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/22/2023 1:19 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1309	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/22/2023 1:19 pm
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,450	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,276	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	625	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	69	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	105	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	294	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	38	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	64	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	250.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	266.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,312,178	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	397,461	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,914,717	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,914,717	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,284.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	671,572	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)	671,572	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/22/2023 1:19 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	229,426	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	900,998	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	86,802	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	146,193	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	232,995	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	651	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,284.26	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,487,053	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/22/2023 1:19 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	343,403	3,312,178	0.103679	1,487,053	154,176	90.00
91.00	Nursing Program cost	0	3,312,178	0.000000	1,487,053	0	91.00
92.00	Allied health cost	0	3,312,178	0.000000	1,487,053	0	92.00
93.00	All other Medical Education	0	3,312,178	0.000000	1,487,053	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1309	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/22/2023 1:19 pm
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,450	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,276	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	625	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	69	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	105	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	13	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	250.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	266.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,312,178	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	397,461	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,914,717	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,914,717	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,284.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	29,695	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)	29,695	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/22/2023 1:19 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	76,271	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	105,966	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	651	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,284.26	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,487,053	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/22/2023 1:19 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	343,403	3,312,178	0.103679	1,487,053	154,176	90.00
91.00	Nursing Program cost	0	3,312,178	0.000000	1,487,053	0	91.00
92.00	Allied health cost	0	3,312,178	0.000000	1,487,053	0	92.00
93.00	All other Medical Education	0	3,312,178	0.000000	1,487,053	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/22/2023 1:19 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		660,650		30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.214713	31,666	6,799	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150490	63,324	9,530	54.00
60.00	06000	LABORATORY	0.223157	146,291	32,646	60.00
65.00	06500	RESPIRATORY THERAPY	0.481747	192,908	92,933	65.00
66.00	06600	PHYSICAL THERAPY	0.388345	52,286	20,305	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.238397	23,466	5,594	67.00
68.00	06800	SPEECH PATHOLOGY	0.505525	2,858	1,445	68.00
69.00	06900	ELECTROCARDIOLOGY	0.102896	2,732	281	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152791	65,167	9,957	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.431121	10,732	4,627	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293567	146,950	43,140	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.252155	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.973142	2,229	2,169	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		740,609	229,426	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		740,609		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1309 | Component CCN: 15-Z309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/22/2023 1:19 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
33.00	03300	BURN INTENSIVE CARE UNIT				33.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.214713	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150490	8,357	1,258	54.00
60.00	06000	LABORATORY	0.223157	20,878	4,659	60.00
65.00	06500	RESPIRATORY THERAPY	0.481747	10,021	4,828	65.00
66.00	06600	PHYSICAL THERAPY	0.388345	47,930	18,613	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.238397	22,098	5,268	67.00
68.00	06800	SPEECH PATHOLOGY	0.505525	1,344	679	68.00
69.00	06900	ELECTROCARDIOLOGY	0.102896	430	44	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152791	1,686	258	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.431121	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293567	16,832	4,941	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.252155	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.973142	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		129,576	40,548	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		129,576		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/22/2023 1:19 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		36,746		30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.214713	50,420	10,826	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150490	16,678	2,510	54.00
60.00	06000	LABORATORY	0.223157	35,679	7,962	60.00
65.00	06500	RESPIRATORY THERAPY	0.481747	12,149	5,853	65.00
66.00	06600	PHYSICAL THERAPY	0.388345	7,976	3,097	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.238397	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.505525	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.102896	5,516	568	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152791	24,167	3,693	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.431121	25,872	11,154	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293567	20,914	6,140	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.252155	23,724	5,982	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.973142	18,996	18,486	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		242,091	76,271	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		242,091		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1309	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/22/2023 1:19 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,453,913	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,453,913	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	3,488,452	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	57,967	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,072,684	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,357,801	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	1,357,801	30.00
31.00	Primary payer payments	895	31.00
32.00	Subtotal (line 30 minus line 31)	1,356,906	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	437,779	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	284,556	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	334,145	36.00
37.00	Subtotal (see instructions)	1,641,462	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,641,462	40.00
40.01	Sequestration adjustment (see instructions)	32,829	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	2,115,996	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-507,363	43.00
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 1, §115.2	25,000	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1309	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/22/2023 1:19 pm
	Title XVIII	Hospital	Cost

			1.00	
	MEDICARE PART B ANCILLARY COSTS			
200.00	Part B Combined Billed Days		0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I Date/Time Prepared: 11/22/2023 1:19 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		974,694		1,935,496	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	02/15/2023	180,500	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		180,500	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		974,694		2,115,996	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		177,841		507,363	6.02
7.00	Total Medicare program liability (see instructions)		796,853		1,608,633	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1309 | Component CCN: 15-Z309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 11/22/2023 1:19 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		340,869		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		340,869		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		69,992		0	6.02
7.00	Total Medicare program liability (see instructions)		270,877		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1309	Period: From 07/01/2022 To 06/30/2023	Worksheet E-1 Part II Date/Time Prepared: 11/22/2023 1:19 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (see instructions)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (see instructions)		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1309 | Component CCN: 15-Z309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-2 | Date/Time Prepared: 11/22/2023 1:19 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	235,325	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	40,953	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	102	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	276,278	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	276,278	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	276,278	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	276,278	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	195	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	127	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	195	0	18.00
19.00	Total (see instructions)	276,405	0	19.00
19.01	Sequestration adjustment (see instructions)	5,528	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	340,869	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	-69,992	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1309	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part V Date/Time Prepared: 11/22/2023 1:19 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	900,998	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	900,998	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	910,008	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	910,008	19.00
20.00	Deductibles (exclude professional component)	106,864	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	803,144	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	803,144	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	15,340	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	9,971	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	15,692	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	813,115	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	813,115	30.00
30.01	Sequestration adjustment (see instructions)	16,262	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	974,694	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-177,841	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	25,000	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-3 Part VII Date/Time Prepared: 11/22/2023 1:19 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	105,966		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	105,966	0	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)	105,966	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	36,746		8.00
9.00	Ancillary service charges	242,091	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	278,837	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	278,837	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	172,871	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	105,966	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	105,966	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	105,966	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	105,966	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	105,966	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	105,966	0	40.00
41.00	Interim payments	105,966	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G | Date/Time Prepared: 11/22/2023 1:19 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	226	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,817,990	0	0	0	4.00
5.00	Other receivable	56,258	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,642,443	0	0	0	6.00
7.00	Inventory	264,284	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	11,717	0	0	0	9.00
10.00	Due from other funds	303,451	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	2,811,483	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,500	0	0	0	12.00
13.00	Land improvements	621,527	0	0	0	13.00
14.00	Accumulated depreciation	-319,390	0	0	0	14.00
15.00	Buildings	11,712,470	0	0	0	15.00
16.00	Accumulated depreciation	-6,229,921	0	0	0	16.00
17.00	Leasehold improvements	995,040	0	0	0	17.00
18.00	Accumulated depreciation	-743,619	0	0	0	18.00
19.00	Fixed equipment	3,421,250	0	0	0	19.00
20.00	Accumulated depreciation	-2,707,290	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	7,264,958	0	0	0	23.00
24.00	Accumulated depreciation	-6,637,977	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	7,379,548	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,401	1,991,532	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,401	1,991,532	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	10,193,432	1,991,532	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	315,519	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,025,744	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	113,285	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,611,210	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,065,758	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	6,763,681	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	10,952	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	6,774,633	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,840,391	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-1,646,959				52.00
53.00	Specific purpose fund		1,991,532			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-1,646,959	1,991,532	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	10,193,432	1,991,532	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-1 | Date/Time Prepared: 11/22/2023 1:19 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-1,076,029		1,957,264		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-655,513				2.00
3.00	Total (sum of line 1 and line 2)		-1,731,542		1,957,264		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	Contributions/Donations/Grant Revenue	195,102		195,102		0	5.00
6.00	Restricted Invest. Income - HSD	0		4,133		0	6.00
7.00		0		0		0	7.00
8.00	Transfer from Affiliates	0		0		0	8.00
9.00	Rounding	0		0		0	9.00
10.00	Total additions (sum of line 4-9)		195,102		199,235		10.00
11.00	Subtotal (line 3 plus line 10)		-1,536,440		2,156,499		11.00
12.00	Transfer from Affiliates	110,519		199,519		0	12.00
13.00		0		0		0	13.00
14.00	Restricted Invest. Income - HSD	0		-34,552		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		110,519		164,967		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-1,646,959		1,991,532		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00	Contributions/Donations/Grant Revenue		0			5.00
6.00	Restricted Invest. Income - HSD		0			6.00
7.00			0			7.00
8.00	Transfer from Affiliates		0			8.00
9.00	Rounding		0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Transfer from Affiliates		0			12.00
13.00			0			13.00
14.00	Restricted Invest. Income - HSD		0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/22/2023 1:19 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,285,691		2,285,691	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,285,691		2,285,691	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	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,285,691		2,285,691	17.00
18.00	Ancillary services	2,240,434	43,674,926	45,915,360	18.00
19.00	Outpatient services	213,051	18,596,332	18,809,383	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	Other Patient Service Revenue	0	612	612	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,739,176	62,271,870	67,011,046	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,363,946		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		20,363,946		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1309 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-3 | Date/Time Prepared: 11/22/2023 1:19 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	67,011,046	1.00
2.00	Less contractual allowances and discounts on patients' accounts	47,553,255	2.00
3.00	Net patient revenues (line 1 minus line 2)	19,457,791	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,363,946	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-906,155	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	14,055	6.00
7.00	Income from investments	93	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	31,175	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	130,229	22.00
23.00	Governmental appropriations	0	23.00
24.00	Misc. Income	15,569	24.00
24.01	Assets Released from Restriction	4,417	24.01
24.50	COVID-19 PHE Funding	55,104	24.50
25.00	Total other income (sum of lines 6-24)	250,642	25.00
26.00	Total (line 5 plus line 25)	-655,513	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-655,513	29.00