

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: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet S Parts I-III Date/Time Prepared: 11/27/2023 8:51 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report 2. <input type="checkbox"/> Manually prepared cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.	Date: 11/27/2023 Time: 8:51 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ASCENSION ST. VINCENT RANDOLPH (15-1301) 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	<i>Chris Hons</i>	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification to be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Chris Hons		2
3	Signatory Title	VP OF FINANCE		3
4	Date	11/27/2023 08:51:07 AM		4

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-33,847	-427,901	0	0 1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	0 2.00
3.00	SUBPROVIDER - IRF	0	0	0	0	0 3.00
5.00	SWING BED - SNF	0	0	0	0	0 5.00
6.00	SWING BED - NF	0	0	0	0	0 6.00
200.00	TOTAL	0	-33,847	-427,901	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: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 11/27/2023 8:51 am
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		1.00	2.00	3.00	4.00					
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 473 GREENVILLE AVE.	PO Box:		Zip Code: 47934		County: RANDOLPH			1.00	
2.00	City: WINCHESTER	State: IN							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 RANDOLPH	151301	99915	1	01/01/2000	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 RANDOLPH SWING	15Z301	99915		09/01/1999	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)				N	N		N	22.03
22.04	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.								22.04
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)								22.04
22.04	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.								22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				2	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1301		Period: From 07/01/2022 To 06/30/2023		Worksheet S-2 Part I Date/Time Prepared: 11/27/2023 8:51 am			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00	
				Urban/Rural S		Date of Geogr			
				1.00		2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.			2				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.			2				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			0				35.00	
				Beginning:		Ending:			
				1.00		2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			0				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.			N					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete wkst. D-5.			N					58.00

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		V	XVIII	XIX		
		1.00	2.00	3.00		
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete wkst. D-2, Pt. I.	N				59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N				60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02
61.03	Enter the 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

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			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	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

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			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)		N	N	0
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)		N	N	0
			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.		N		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
			1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.				0
			wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge
			1.00	2.00	3.00
89.00	Column 1: If line 88, column 1 is Y, enter the worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.		0.00		0
			V	XIX	
			1.00	2.00	
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	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1301		Period: From 07/01/2022 To 06/30/2023		Worksheet S-2 Part I Date/Time Prepared: 11/27/2023 8:51 am	
		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 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	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			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N		111.00	
				1.00			
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.			N		112.00	
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		0115.00	
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: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 11/27/2023 8:51 am
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	152,186	0	0
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N	118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y	121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the worksheet A line number where these taxes are included.		Y	5.00
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
		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: ST. VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08001	141.00
142.00	Street: 250 WEST 96TH ST 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: 15-1301		Period: From 07/01/2022 To 06/30/2023		Worksheet S-2 Part I Date/Time Prepared: 11/27/2023 8:51 am		
1.00								
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00
		Part A	Part B	Title v	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N		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	
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.						N	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)						Y	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)							
		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: 15-1301		Period: From 07/01/2022 To 06/30/2023		Worksheet S-2 Part II Date/Time Prepared: 11/27/2023 8:51 am	
		Y/N	Date				
		1.00	2.00				
PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE							
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
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					2.00
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

		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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-1301

Period:
From 07/01/2022
To 06/30/2023

Worksheet S-2
Part II
Date/Time Prepared:
11/27/2023 8:51 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1301

Period:
From 07/01/2022
To 06/30/2023

Worksheet S-3
Part I
Date/Time Prepared:
11/27/2023 8:51 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips		
	Line No.				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	21,144.00	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	21,144.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	21,144.00	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: 15-1301

Period:
From 07/01/2022
To 06/30/2023

Worksheet S-3
Part I
Date/Time Prepared:
11/27/2023 8:51 am

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)	225	31	881		1.00
2.00	HMO and other (see instructions)	128	305			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	16		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	11		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	225	31	908		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		31	344		13.00
14.00	Total (see instructions)	225	62	1,252	0.00	58.30
15.00	CAH visits	9,164	942	44,346		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
27.00	Total (sum of lines 14-26)				0.00	58.30
28.00	Observation Bed Days		0	187		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			45		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	4	106		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

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	55	22	410	1.00
2.00	HMO and other (see instructions)			38	133		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	55	22	410	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: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet S-10 Date/Time Prepared: 11/27/2023 8:51 am
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.199318	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		8,212,258	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		33,820,285	6.00	
7.00	Medicaid cost (line 1 times line 6)		6,740,992	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		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)		0	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)	1,739,480	1,178,025	2,917,505	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	346,710	1,178,025	1,524,735	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)	346,710	1,178,025	1,524,735	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)		2,386,306		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		337,790		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		519,676		27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,866,630		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		553,939		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,078,674		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,078,674		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-1301

Period:
From 07/01/2022
To 06/30/2023

Worksheet A

Date/Time Prepared:
11/27/2023 8:51 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		782,574	782,574	0	782,574	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		457,656	457,656	0	457,656	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	133,018	1,297,446	1,430,464	0	1,430,464	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	285,666	7,579,521	7,865,187	0	7,865,187	5.00
7.00	00700	OPERATION OF PLANT	0	1,173,867	1,173,867	0	1,173,867	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,781	10,781	0	10,781	8.00
9.00	00900	HOUSEKEEPING	0	471,873	471,873	0	471,873	9.00
10.00	01000	DIETARY	0	400,523	400,523	-340,585	59,938	10.00
11.00	01100	CAFETERIA	0	0	0	340,585	340,585	11.00
13.00	01300	NURSING ADMINISTRATION	322,028	38,336	360,364	0	360,364	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,362	2,362	0	2,362	14.00
15.00	01500	PHARMACY	212,485	1,526,681	1,739,166	-4	1,739,162	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	1,464,930	192,302	1,657,232	-893,448	763,784	30.00
43.00	04300	NURSERY	0	0	0	233,808	233,808	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	458,922	194,801	653,723	-96,405	557,318	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	653,014	653,014	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	886,805	1,503,593	2,390,398	-467	2,389,931	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	2,028,777	2,028,777	0	2,028,777	60.00
65.00	06500	RESPIRATORY THERAPY	314,275	17,168	331,443	0	331,443	65.00
65.01	03950	SLEEP LAB	88,886	4,771	93,657	0	93,657	65.01
66.00	06600	PHYSICAL THERAPY	11,721	349,296	361,017	0	361,017	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,062	29,572	30,634	0	30,634	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	75,472	75,472	136,632	212,104	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,228	23,228	0	23,228	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	164,269	14,577	178,846	0	178,846	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	133,992	30,314	164,306	-27,763	136,543	90.00
91.00	09100	EMERGENCY	811,803	1,076,981	1,888,784	-5,367	1,883,417	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)	5,289,862	19,282,472	24,572,334	0	24,572,334	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	35,623	-11,575	24,048	0	24,048	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	0	0	0	0	0	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	5,325,485	19,270,897	24,596,382	0	24,596,382	200.00

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	111,928	894,502	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	457,656	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	76,303	1,506,767	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,857,798	5,007,389	5.00
7.00	00700	OPERATION OF PLANT	0	1,173,867	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,781	8.00
9.00	00900	HOUSEKEEPING	0	471,873	9.00
10.00	01000	DIETARY	0	59,938	10.00
11.00	01100	CAFETERIA	-47,014	293,571	11.00
13.00	01300	NURSING ADMINISTRATION	-4,125	356,239	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,362	14.00
15.00	01500	PHARMACY	0	1,739,162	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	763,784	30.00
43.00	04300	NURSERY	0	233,808	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	557,318	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-221	652,793	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,389,931	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	-1,541	2,027,236	60.00
65.00	06500	RESPIRATORY THERAPY	0	331,443	65.00
65.01	03950	SLEEP LAB	0	93,657	65.01
66.00	06600	PHYSICAL THERAPY	0	361,017	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	30,634	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-43,286	168,818	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,228	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	178,846	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	136,543	90.00
91.00	09100	EMERGENCY	0	1,883,417	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)	-2,765,754	21,806,580	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	24,048	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	0	0	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,765,754	21,830,628	200.00

Provider CCN: 15-1301

Period:
From 07/01/2022
To 06/30/2023

Worksheet A-6
Date/Time Prepared:
11/27/2023 8:51 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	0	340,585	1.00
	TOTALS		0	340,585	
B - NURSERY RECLASS					
1.00	NURSERY	43.00	204,627	30,386	1.00
			204,627	30,386	
C - DELIVERY & LABOR ROOM					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	571,513	84,866	1.00
			571,513	84,866	
D - MEDICAL SUPPLIES CHARGED TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		136,632	1.00
2.00					2.00
3.00					3.00
4.00					4.00
5.00					5.00
6.00					6.00
7.00					7.00
8.00					8.00
			0	136,632	
500.00	Grand Total: Increases		776,140	592,469	500.00

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	340,585	0	1.00
	TOTALS		0	340,585		
B - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	204,627	30,386		1.00
			204,627	30,386		
C - DELIVERY & LABOR ROOM						
1.00	ADULTS & PEDIATRICS	30.00	571,513	84,866		1.00
			571,513	84,866		
D - MEDICAL SUPPLIES CHARGED TO PATIENTS						
1.00	PHARMACY	15.00		4		1.00
2.00	ADULTS & PEDIATRICS	30.00		2,056		2.00
3.00	NURSERY	43.00		1,205		3.00
4.00	OPERATING ROOM	50.00		96,405		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00		3,365		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00		467		6.00
7.00	CLINIC	90.00		27,763		7.00
8.00	EMERGENCY	91.00		5,367		8.00
			0	136,632		
500.00	Grand Total: Decreases		776,140	592,469		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1301

Period:
From 07/01/2022
To 06/30/2023

Worksheet A-7
Part I
Date/Time Prepared:
11/27/2023 8:51 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	696,652	0	0	0	1.00
2.00	Land Improvements	411,658	39,546	0	39,546	2.00
3.00	Buildings and Fixtures	19,284,430	153,810	0	153,810	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	1,767,458	18,750	0	18,750	5.00
6.00	Movable Equipment	7,741,156	318,024	0	318,024	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	29,901,354	530,130	0	530,130	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	29,901,354	530,130	0	530,130	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	696,652	0			1.00
2.00	Land Improvements	451,204	0			2.00
3.00	Buildings and Fixtures	19,438,240	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	1,786,208	0			5.00
6.00	Movable Equipment	8,059,180	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	30,431,484	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	30,431,484	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1301

Period:
From 07/01/2022
To 06/30/2023

Worksheet A-7
Part II
Date/Time Prepared:
11/27/2023 8:51 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	782,327	0	0	0	247	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	457,656	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,239,983	0	0	0	247	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	782,574				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	457,656				2.00
3.00	Total (sum of lines 1-2)	0	1,240,230				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1301

Period:
From 07/01/2022
To 06/30/2023

Worksheet A-7
Part III
Date/Time Prepared:
11/27/2023 8:51 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	22,372,304	0	22,372,304	0.735170	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,059,180	0	8,059,180	0.264830	0	2.00
3.00	Total (sum of lines 1-2)	30,431,484	0	30,431,484	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	894,255	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	457,656	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,351,911	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	247	0	894,502	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	457,656	2.00
3.00	Total (sum of lines 1-2)	0	0	247	0	1,352,158	3.00

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Ref.
				Cost Center	Line #	Wkst. A-7	
				1.00	2.00	3.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-264,965	CAP REL COSTS-BLDG & FIXT	1.00		9 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	-8,229	ADMINISTRATIVE & GENERAL	5.00		9 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	-7,500				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	451,547				0 12.00
13.00	Laundry and linen service		0		0.00		0 13.00
14.00	Cafeteria-employees and guests	B	-47,014	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	MISCELLANEOUS REVENUE	B	-575	ADMINISTRATIVE & GENERAL	5.00		0 33.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
33.01 MISCELLANEOUS REVENUE	B	-221	DELIVERY ROOM & LABOR ROOM	52.00	0	33.01
33.04 LAB SERVICES REVENUE	B	-1,541	LABORATORY	60.00	0	33.04
33.09 PROMOTIONAL ITEMS	A	-356	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.11 CORPORATE SPONSORSHIP	A	-30,000	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.17 LOBBYING OFFSET	A	-510	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18 PROVIDER ASSESSMENT TAX ADJUSTMENT	A	-1,795,590	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.20 PAVILION DEPRECIATION	A	-2,507	CAP REL COSTS-BLDG & FIXT	1.00	9	33.20
33.21 CARRYFORWARD ON HOSPITAL DEPR.	A	-104,668	CAP REL COSTS-BLDG & FIXT	1.00	9	33.21
33.24 Physician Fund Expense	A	-21,771	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.24
33.25 Physician Fund Expense	A	-931,854	ADMINISTRATIVE & GENERAL	5.00	0	33.25
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-2,765,754				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: 15-1301
 Period: From 07/01/2022 To 06/30/2023
 Worksheet A-8-1
 Date/Time Prepared: 11/27/2023 8:51 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED					
HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - CAPITAL	281,895	0
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - INTEREST	10,468	0
3.00	5.00	ADMINISTRATIVE & GENERAL	Home Office - Interest - A&G	87	0
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - OTHER	3,250,664	3,112,365
3.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	180	180
3.03	15.00	PHARMACY	SVH CHARGEBACKS	4,000	4,000
3.04	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACKS	259,620	259,620
3.05	91.00	EMERGENCY	SVH CHARGEBACKS	3,200	3,200
3.06	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	776,294	678,220
3.07	71.00	MEDICAL SUPPLIES CHARGED TO	TRG Admin Fees - Supplies	-43,286	0
3.08	5.00	ADMINISTRATIVE & GENERAL	TRG Admin Fees - Other	-30,360	0
3.09	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	484,068	0
3.10	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	3,951	487,524
3.11	13.00	NURSING ADMINISTRATION	TRG Admin Fees - Contracted	-4,125	0
4.00	0.00			0	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,996,656	4,545,109

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

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

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

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

6.00	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: 15-1301

Period:
From 07/01/2022
To 06/30/2023

Worksheet A-8-1

Date/Time Prepared:
11/27/2023 8:51 am

	Net Adjustments (col. 4 minus col. 5)*	wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	281,895	0		1.00
2.00	10,468	0		2.00
3.00	87	0		3.00
3.01	138,299	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
3.06	98,074	0		3.06
3.07	-43,286	0		3.07
3.08	-30,360	0		3.08
3.09	484,068	9		3.09
3.10	-483,573	0		3.10
3.11	-4,125	0		3.11
4.00	0	0		4.00
5.00	451,547			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: 15-1301

Period:
From 07/01/2022
To 06/30/2023

Worksheet A-8-2

Date/Time Prepared:
11/27/2023 8:51 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	7,500	7,500	0	0	0	1.00
2.00	91.00	EMERGENCY	938,451	0	938,451	0	0	2.00
3.00	0.00		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			945,951	7,500	938,451			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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	0.00		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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	7,500		1.00
2.00	91.00	EMERGENCY	0	0	0	0		2.00
3.00	0.00		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	7,500		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 15-1301		Period: From 07/01/2022 To 06/30/2023		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/27/2023 8:51 am	
		Physical Therapy				Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					50	1.00
2.00	Line 1 multiplied by 15 hours per week					750	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					11	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)					37	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	2,044.00	1,230.00	2,665.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	110.02	95.97	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)	47.99	47.99	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)					224,881	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					118,043	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					165,736	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					508,660	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)					508,660	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)					508,660	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)					528	24.00
25.00	Assistants (line 4 times column 3, line 11)					1,151	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					1,679	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)					459	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					2,138	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)					2,138	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: 15-1301				Period: From 07/01/2022 To 06/30/2023		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/27/2023 8:51 am	
							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	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	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	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	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	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	95.97	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)						508,660	57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						2,138	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)						510,798	63.00	
64.00	Total cost of outside supplier services (from your records)						302,498	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						1,679	100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						459	100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27						2,138	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						459	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						459	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: 15-1301		Period: From 07/01/2022 To 06/30/2023		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/27/2023 8:51 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					1	1.00
2.00	Line 1 multiplied by 15 hours per week					15	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					1	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	8.00	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)					726	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					726	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)					726	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)					90.75	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					1,361	22.00
23.00	Total salary equivalency (see instructions)					1,361	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)					45	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)					45	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)					10	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					55	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)					55	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: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/27/2023 8:51 am
		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)					1,361	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					55	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)					1,416	63.00
64.00	Total cost of outside supplier services (from your records)					407	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					45	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					10	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					55	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					10	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					10	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: 15-1301		Period: From 07/01/2022 To 06/30/2023		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/27/2023 8:51 am	
		Speech Pathology		Cost			
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					40	1.00
2.00	Line 1 multiplied by 15 hours per week					600	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					76	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	601.00	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)					52,389	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					52,389	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)					52,389	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)					52,389	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)					3,313	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)					3,313	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)					727	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					4,040	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)					4,040	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: 15-1301				Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/27/2023 8:51 am
						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	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	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	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	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	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)					52,389	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					4,040	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)					56,429	63.00
64.00	Total cost of outside supplier services (from your records)					30,611	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					3,313	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					727	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					4,040	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					727	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					727	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: 15-1301

Period:
From 07/01/2022
To 06/30/2023

Worksheet B
Part I
Date/Time Prepared:
11/27/2023 8:51 am

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	894,502	894,502			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	457,656		457,656		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,506,767	0	0	1,506,767	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,007,389	134,281	68,703	80,838	5,291,211
7.00 00700	OPERATION OF PLANT	1,173,867	54,383	27,824	0	1,256,074
8.00 00800	LAUNDRY & LINEN SERVICE	10,781	7,297	3,733	0	21,811
9.00 00900	HOUSEKEEPING	471,873	6,841	3,500	0	482,214
10.00 01000	DIETARY	59,938	25,379	12,985	0	98,302
11.00 01100	CAFETERIA	293,571	5,974	3,057	0	302,602
13.00 01300	NURSING ADMINISTRATION	356,239	1,642	840	93,582	452,303
14.00 01400	CENTRAL SERVICES & SUPPLY	2,362	0	0	0	2,362
15.00 01500	PHARMACY	1,739,162	0	0	61,749	1,800,911
16.00 01600	MEDICAL RECORDS & LIBRARY	0	16,908	8,651	0	25,559
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	763,784	100,352	51,343	200,164	1,115,643
43.00 04300	NURSERY	233,808	1,425	729	59,465	295,427
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	557,318	88,974	45,522	133,364	825,178
52.00 05200	DELIVERY ROOM & LABOR ROOM	652,793	26,781	13,702	166,083	859,359
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,389,931	70,949	36,300	257,708	2,754,888
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00 06000	LABORATORY	2,027,236	19,872	10,167	0	2,057,275
65.00 06500	RESPIRATORY THERAPY	331,443	22,426	11,474	91,329	456,672
65.01 03950	SLEEP LAB	93,657	4,834	2,473	25,831	126,795
66.00 06600	PHYSICAL THERAPY	361,017	35,343	18,083	3,406	417,849
67.00 06700	OCCUPATIONAL THERAPY	0	3,614	1,849	0	5,463
68.00 06800	SPEECH PATHOLOGY	30,634	0	0	309	30,943
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	168,818	19,188	9,817	0	197,823
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	23,228	0	0	0	23,228
73.00 07300	DRUGS CHARGED TO PATIENTS	178,846	16,999	8,697	47,737	252,279
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	136,543	0	0	38,938	175,481
91.00 09100	EMERGENCY	1,883,417	49,344	25,246	235,912	2,193,919
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	21,806,580	712,806	364,695	1,496,415	21,521,571
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,394	1,225	0	3,619
192.00 19200	PHYSICIANS' PRIVATE OFFICES	24,048	177,798	90,966	10,352	303,164
194.00 07950	OTHER NRCC - PUBLIC RELATIONS	0	752	385	0	1,137
194.01 07951	OTHER NRCC - FOUNDATION	0	752	385	0	1,137
194.02 07952	OTHER NRCC - GRANTS	0	0	0	0	0
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	21,830,628	894,502	457,656	1,506,767	21,830,628

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1301

Period:
From 07/01/2022
To 06/30/2023

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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	5,291,211				5.00
7.00	00700	OPERATION OF PLANT	401,837	1,657,911			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,978	17,139	45,928		8.00
9.00	00900	HOUSEKEEPING	154,267	16,068	0	652,549	9.00
10.00	01000	DIETARY	31,448	59,611	0	23,942	10.00
11.00	01100	CAFETERIA	96,807	14,032	0	5,636	11.00
13.00	01300	NURSING ADMINISTRATION	144,699	3,856	0	1,549	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	756	0	0	0	14.00
15.00	01500	PHARMACY	576,138	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,177	39,714	0	15,951	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	356,911	235,712	33,031	94,672	30.00
43.00	04300	NURSERY	94,512	3,347	12,897	1,344	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	263,987	208,986	0	83,938	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	274,922	62,905	0	25,265	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	881,330	166,648	0	66,933	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	658,153	46,676	0	18,747	60.00
65.00	06500	RESPIRATORY THERAPY	146,096	52,675	0	21,156	65.00
65.01	03950	SLEEP LAB	40,564	11,354	0	4,560	65.01
66.00	06600	PHYSICAL THERAPY	133,676	83,016	0	33,343	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,748	8,489	0	3,410	67.00
68.00	06800	SPEECH PATHOLOGY	9,899	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	63,287	45,070	0	18,102	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,431	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	80,708	39,928	0	16,037	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	56,139	0	0	0	90.00
91.00	09100	EMERGENCY	701,868	115,901	0	46,551	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)	5,192,338	1,231,127	45,928	481,136	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,158	5,624	0	2,259	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	96,987	417,626	0	167,734	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	364	1,767	0	710	194.00
194.01	07951	OTHER NRCC - FOUNDATION	364	1,767	0	710	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,291,211	1,657,911	45,928	652,549	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet B Part I Date/Time Prepared: 11/27/2023 8:51 am
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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						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	419,077					11.00
13.00	01300	27,906	630,313				13.00
14.00	01400	0	0	3,118			14.00
15.00	01500	17,652	0	0	2,394,701		15.00
16.00	01600	0	0	0	0	89,401	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	61,131	165,044	0	0	2,547	30.00
43.00	04300	16,227	43,810	0	0	817	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	38,110	102,889	0	0	6,460	50.00
52.00	05200	45,323	122,364	0	0	2,281	52.00
54.00	05400	76,954	0	0	0	23,712	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	0	0	0	26,928	60.00
65.00	06500	24,693	0	0	0	2,889	65.00
65.01	03950	8,822	0	0	0	966	65.01
66.00	06600	1,382	0	0	0	1,396	66.00
67.00	06700	0	0	0	0	224	67.00
68.00	06800	102	0	0	0	128	68.00
71.00	07100	0	0	2,810	0	0	71.00
72.00	07200	0	0	308	0	0	72.00
73.00	07300	12,697	0	0	2,394,701	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	10,153	0	0	0	753	90.00
91.00	09100	72,673	196,206	0	0	20,300	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		413,825	630,313	3,118	2,394,701	89,401	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	5,252	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		419,077	630,313	3,118	2,394,701	89,401	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1301

Period:
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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	2,277,994	0	2,277,994
43.00	04300	NURSERY	468,381	0	468,381
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,529,548	0	1,529,548
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,392,419	0	1,392,419
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,970,465	0	3,970,465
57.00	05700	CT SCAN	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0
60.00	06000	LABORATORY	2,807,779	0	2,807,779
65.00	06500	RESPIRATORY THERAPY	704,181	0	704,181
65.01	03950	SLEEP LAB	193,061	0	193,061
66.00	06600	PHYSICAL THERAPY	670,662	0	670,662
67.00	06700	OCCUPATIONAL THERAPY	19,334	0	19,334
68.00	06800	SPEECH PATHOLOGY	41,072	0	41,072
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	327,092	0	327,092
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,967	0	30,967
73.00	07300	DRUGS CHARGED TO PATIENTS	2,796,350	0	2,796,350
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	242,526	0	242,526
91.00	09100	EMERGENCY	3,347,418	0	3,347,418
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,819,249	0	20,819,249
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,660	0	12,660
192.00	19200	PHYSICIANS' PRIVATE OFFICES	990,763	0	990,763
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	3,978	0	3,978
194.01	07951	OTHER NRCC - FOUNDATION	3,978	0	3,978
194.02	07952	OTHER NRCC - GRANTS	0	0	0
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118 through 201)	21,830,628	0	21,830,628

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet B Part II Date/Time Prepared: 11/27/2023 8:51 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	282,307	134,281	68,703	485,291	5.00
7.00 00700	OPERATION OF PLANT	0	54,383	27,824	82,207	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	7,297	3,733	11,030	8.00
9.00 00900	HOUSEKEEPING	0	6,841	3,500	10,341	9.00
10.00 01000	DIETARY	0	25,379	12,985	38,364	10.00
11.00 01100	CAFETERIA	0	5,974	3,057	9,031	11.00
13.00 01300	NURSING ADMINISTRATION	0	1,642	840	2,482	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	16,908	8,651	25,559	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,019	100,352	51,343	152,714	30.00
43.00 04300	NURSERY	0	1,425	729	2,154	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	88,974	45,522	134,496	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	26,781	13,702	40,483	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	251,606	70,949	36,300	358,855	54.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00 06000	LABORATORY	0	19,872	10,167	30,039	60.00
65.00 06500	RESPIRATORY THERAPY	0	22,426	11,474	33,900	65.00
65.01 03950	SLEEP LAB	1,522	4,834	2,473	8,829	65.01
66.00 06600	PHYSICAL THERAPY	0	35,343	18,083	53,426	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	3,614	1,849	5,463	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19,188	9,817	29,005	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	16,999	8,697	25,696	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	49,344	25,246	74,590	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)	536,454	712,806	364,695	1,613,955	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,394	1,225	3,619	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	177,798	90,966	268,764	192.00
194.00 07950	OTHER NRCC - PUBLIC RELATIONS	0	752	385	1,137	194.00
194.01 07951	OTHER NRCC - FOUNDATION	0	752	385	1,137	194.01
194.02 07952	OTHER NRCC - GRANTS	0	0	0	0	194.02
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	536,454	894,502	457,656	1,888,612	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1301

Period:
From 07/01/2022
To 06/30/2023

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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	485,291					5.00
7.00	00700	OPERATION OF PLANT	36,854	119,061				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	640	1,231	12,901			8.00
9.00	00900	HOUSEKEEPING	14,149	1,154	0	25,644		9.00
10.00	01000	DIETARY	2,884	4,281	0	941	46,470	10.00
11.00	01100	CAFETERIA	8,879	1,008	0	221	0	11.00
13.00	01300	NURSING ADMINISTRATION	13,271	277	0	61	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	69	0	0	0	0	14.00
15.00	01500	PHARMACY	52,841	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	750	2,852	0	627	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	32,734	16,927	9,278	3,720	46,470	30.00
43.00	04300	NURSERY	8,668	240	3,623	53	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	24,212	15,008	0	3,299	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,214	4,517	0	993	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	80,840	11,968	0	2,630	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	60,363	3,352	0	737	0	60.00
65.00	06500	RESPIRATORY THERAPY	13,399	3,783	0	831	0	65.00
65.01	03950	SLEEP LAB	3,720	815	0	179	0	65.01
66.00	06600	PHYSICAL THERAPY	12,260	5,962	0	1,310	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	160	610	0	134	0	67.00
68.00	06800	SPEECH PATHOLOGY	908	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,804	3,237	0	711	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	682	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,402	2,867	0	630	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,149	0	0	0	0	90.00
91.00	09100	EMERGENCY	64,372	8,323	0	1,829	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)	476,224	88,412	12,901	18,906	46,470	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	106	404	0	89	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,895	29,991	0	6,593	0	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	33	127	0	28	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	33	127	0	28	0	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0	0	194.02
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)	485,291	119,061	12,901	25,644	46,470	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1301

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To 06/30/2023

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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	19,139					11.00
13.00	01300	NURSING ADMINISTRATION	1,274	17,365				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	69			14.00
15.00	01500	PHARMACY	806	0	0	53,647		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	29,788	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,792	4,547	0	0	848	30.00
43.00	04300	NURSERY	741	1,207	0	0	272	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,740	2,835	0	0	2,151	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,070	3,371	0	0	760	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,514	0	0	0	7,896	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	8,984	60.00
65.00	06500	RESPIRATORY THERAPY	1,128	0	0	0	962	65.00
65.01	03950	SLEEP LAB	403	0	0	0	322	65.01
66.00	06600	PHYSICAL THERAPY	63	0	0	0	465	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	74	67.00
68.00	06800	SPEECH PATHOLOGY	5	0	0	0	43	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	62	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	7	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	580	0	0	53,647	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	464	0	0	0	251	90.00
91.00	09100	EMERGENCY	3,319	5,405	0	0	6,760	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)		18,899	17,365	69	53,647	29,788	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	240	0	0	0	0	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	0	0	0	0	0	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0	0	194.02
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)		19,139	17,365	69	53,647	29,788	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1301

Period:
From 07/01/2022
To 06/30/2023

Worksheet B
Part II
Date/Time Prepared:
11/27/2023 8:51 am

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	270,030	0	270,030
43.00	04300	NURSERY	16,958	0	16,958
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	183,741	0	183,741
52.00	05200	DELIVERY ROOM & LABOR ROOM	77,408	0	77,408
54.00	05400	RADIOLOGY-DIAGNOSTIC	465,703	0	465,703
57.00	05700	CT SCAN	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0
60.00	06000	LABORATORY	103,475	0	103,475
65.00	06500	RESPIRATORY THERAPY	54,003	0	54,003
65.01	03950	SLEEP LAB	14,268	0	14,268
66.00	06600	PHYSICAL THERAPY	73,486	0	73,486
67.00	06700	OCCUPATIONAL THERAPY	6,441	0	6,441
68.00	06800	SPEECH PATHOLOGY	956	0	956
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	38,819	0	38,819
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	689	0	689
73.00	07300	DRUGS CHARGED TO PATIENTS	90,822	0	90,822
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	5,864	0	5,864
91.00	09100	EMERGENCY	164,598	0	164,598
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,567,261	0	1,567,261
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,218	0	4,218
192.00	19200	PHYSICIANS' PRIVATE OFFICES	314,483	0	314,483
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	1,325	0	1,325
194.01	07951	OTHER NRCC - FOUNDATION	1,325	0	1,325
194.02	07952	OTHER NRCC - GRANTS	0	0	0
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118 through 201)	1,888,612	0	1,888,612

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1301

Period:
From 07/01/2022
To 06/30/2023

Worksheet B-1
Date/Time Prepared:
11/27/2023 8:51 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	78,458				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		78,458			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	5,184,973		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	11,778	11,778	278,172	-5,291,211	16,539,417 5.00
7.00 00700	OPERATION OF PLANT	4,770	4,770	0	0	1,256,074 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	640	640	0	0	21,811 8.00
9.00 00900	HOUSEKEEPING	600	600	0	0	482,214 9.00
10.00 01000	DIETARY	2,226	2,226	0	0	98,302 10.00
11.00 01100	CAFETERIA	524	524	0	0	302,602 11.00
13.00 01300	NURSING ADMINISTRATION	144	144	322,028	0	452,303 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	2,362 14.00
15.00 01500	PHARMACY	0	0	212,485	0	1,800,911 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,483	1,483	0	0	25,559 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	8,802	8,802	688,790	0	1,115,643 30.00
43.00 04300	NURSERY	125	125	204,627	0	295,427 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	7,804	7,804	458,922	0	825,178 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	2,349	2,349	571,513	0	859,359 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	6,223	6,223	886,805	0	2,754,888 54.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
60.00 06000	LABORATORY	1,743	1,743	0	0	2,057,275 60.00
65.00 06500	RESPIRATORY THERAPY	1,967	1,967	314,275	0	456,672 65.00
65.01 03950	SLEEP LAB	424	424	88,886	0	126,795 65.01
66.00 06600	PHYSICAL THERAPY	3,100	3,100	11,721	1,100	417,849 66.00
67.00 06700	OCCUPATIONAL THERAPY	317	317	0	0	5,463 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	1,062	0	30,943 68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,683	1,683	0	0	197,823 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	23,228 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,491	1,491	164,269	0	252,279 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	133,992	0	175,481 90.00
91.00 09100	EMERGENCY	4,328	4,328	811,803	0	2,193,919 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)	62,521	62,521	5,149,350	-5,291,211	16,230,360 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	210	210	0	0	3,619 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	15,595	15,595	35,623	0	303,164 192.00
194.00 07950	OTHER NRCC - PUBLIC RELATIONS	66	66	0	0	1,137 194.00
194.01 07951	OTHER NRCC - FOUNDATION	66	66	0	0	1,137 194.01
194.02 07952	OTHER NRCC - GRANTS	0	0	0	0	0 194.02
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)	894,502	457,656	1,506,767		5,291,211 202.00
203.00	Unit cost multiplier (wkst. B, Part I)	11.401030	5.833134	0.290603		0.319915 203.00
204.00	Cost to be allocated (per wkst. B, Part II)			0		485,291 204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.000000		0.029341 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: 15-1301

Period:
From 07/01/2022
To 06/30/2023

Worksheet B-1

Date/Time Prepared:
11/27/2023 8:51 am

Cost Center Description		OPERATION OF PLANT (SQURE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	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	61,910				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	640	1,225			8.00
9.00	00900	HOUSEKEEPING	600	0	60,670		9.00
10.00	01000	DIETARY	2,226	0	2,226	100	10.00
11.00	01100	CAFETERIA	524	0	524	0	11.00
13.00	01300	NURSING ADMINISTRATION	144	0	144	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,483	0	1,483	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,802	881	8,802	100	30.00
43.00	04300	NURSERY	125	344	125	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,804	0	7,804	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,349	0	2,349	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,223	0	6,223	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	1,743	0	1,743	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,967	0	1,967	0	65.00
65.01	03950	SLEEP LAB	424	0	424	0	65.01
66.00	06600	PHYSICAL THERAPY	3,100	0	3,100	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	317	0	317	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,683	0	1,683	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,491	0	1,491	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,328	0	4,328	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)	45,973	1,225	44,733	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	210	0	210	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,595	0	15,595	0	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	66	0	66	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	66	0	66	0	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0	194.02
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)	1,657,911	45,928	652,549	213,303	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	26.779373	37.492245	10.755711	2,133.030000	203.00
204.00		Cost to be allocated (per wkst. B, Part II)	119,061	12,901	25,644	46,470	204.00
205.00		Unit cost multiplier (wkst. B, Part II)	1.923130	10.531429	0.422680	464.700000	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: 15-1301

Period:
From 07/01/2022
To 06/30/2023

Worksheet B-1
Date/Time Prepared:
11/27/2023 8:51 am

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					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	59,650				13.00
14.00	01400	0	235,332			14.00
15.00	01500	0	0	10,000		15.00
16.00	01600	0	0	0	93,947,541	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	15,619	0	0	2,675,034	30.00
43.00	04300	4,146	0	0	857,979	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	9,737	0	0	6,785,216	50.00
52.00	05200	11,580	0	0	2,396,293	52.00
54.00	05400	0	0	0	24,907,704	54.00
57.00	05700	0	0	0	0	57.00
58.00	05800	0	0	0	0	58.00
60.00	06000	0	0	0	28,325,369	60.00
65.00	06500	0	0	0	3,035,031	65.00
65.01	03950	0	0	0	1,014,506	65.01
66.00	06600	0	0	0	1,466,560	66.00
67.00	06700	0	0	0	234,861	67.00
68.00	06800	0	0	0	134,400	68.00
71.00	07100	0	212,104	0	0	71.00
72.00	07200	0	23,228	0	0	72.00
73.00	07300	0	0	10,000	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	0	0	0	791,165	90.00
91.00	09100	18,568	0	0	21,323,423	91.00
92.00	09200					92.00
SPECIAL PURPOSE COST CENTERS						
118.00		59,650	235,332	10,000	93,947,541	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	0	0	0	192.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
194.02	07952	0	0	0	0	194.02
200.00						200.00
201.00						201.00
202.00		630,313	3,118	2,394,701	89,401	202.00
203.00		10.566857	0.013249	239.470100	0.000952	203.00
204.00		17,365	69	53,647	29,788	204.00
205.00		0.291115	0.000293	5.364700	0.000317	205.00
206.00						206.00
207.00						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Prepared: 11/27/2023 8:51 am
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		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		2,277,994		0	30.00
43.00	04300 NURSERY		468,381		0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		1,529,548		0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,392,419		0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		3,970,465		0	54.00
57.00	05700 CT SCAN		0		0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0		0	58.00
60.00	06000 LABORATORY		2,807,779		0	60.00
65.00	06500 RESPIRATORY THERAPY	0	704,181		0	65.00
65.01	03950 SLEEP LAB	0	193,061		0	65.01
66.00	06600 PHYSICAL THERAPY	0	670,662		0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	19,334		0	67.00
68.00	06800 SPEECH PATHOLOGY	0	41,072		0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		327,092		0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		30,967		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		2,796,350		0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		242,526		0	90.00
91.00	09100 EMERGENCY		3,347,418		0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		392,500		0	92.00
200.00	Subtotal (see instructions)	0	21,211,749		0	200.00
201.00	Less observation Beds		392,500		0	201.00
202.00	Total (see instructions)	0	20,819,249		0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Prepared: 11/27/2023 8:51 am
		Title XVIII	Hospital	Cost

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,282,380		2,282,380	30.00
43.00	04300	NURSERY	857,979		857,979	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,208,433	5,576,783	6,785,216	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,822,185	574,108	2,396,293	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	525,645	24,382,059	24,907,704	54.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
60.00	06000	LABORATORY	1,292,474	27,032,895	28,325,369	60.00
65.00	06500	RESPIRATORY THERAPY	511,118	2,523,913	3,035,031	65.00
65.01	03950	SLEEP LAB	0	1,014,506	1,014,506	65.01
66.00	06600	PHYSICAL THERAPY	48,014	1,418,546	1,466,560	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,514	209,347	234,861	67.00
68.00	06800	SPEECH PATHOLOGY	1,611	132,789	134,400	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	329,797	896,977	1,226,774	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	59,835	59,835	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	753,417	8,464,955	9,218,372	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,381	787,784	791,165	90.00
91.00	09100	EMERGENCY	313,845	21,009,578	21,323,423	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	62,078	330,576	392,654	92.00
200.00		Subtotal (see instructions)	10,037,871	94,414,651	104,452,522	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	10,037,871	94,414,651	104,452,522	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Prepared: 11/27/2023 8:51 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital
		11.00		Cost
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
65.01	03950 SLEEP LAB	0.000000		65.01
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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Prepared: 11/27/2023 8:51 am
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		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		2,277,994		0	2,277,994	30.00
43.00	04300 NURSERY		468,381		0	468,381	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		1,529,548		0	1,529,548	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,392,419		0	1,392,419	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		3,970,465		0	3,970,465	54.00
57.00	05700 CT SCAN		0		0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0		0	0	58.00
60.00	06000 LABORATORY		2,807,779		0	2,807,779	60.00
65.00	06500 RESPIRATORY THERAPY	0	704,181		0	704,181	65.00
65.01	03950 SLEEP LAB	0	193,061		0	193,061	65.01
66.00	06600 PHYSICAL THERAPY	0	670,662		0	670,662	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	19,334		0	19,334	67.00
68.00	06800 SPEECH PATHOLOGY	0	41,072		0	41,072	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		327,092		0	327,092	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		30,967		0	30,967	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		2,796,350		0	2,796,350	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC		242,526		0	242,526	90.00
91.00	09100 EMERGENCY		3,347,418		0	3,347,418	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		392,500		0	392,500	92.00
200.00	Subtotal (see instructions)		21,211,749	0	0	21,211,749	200.00
201.00	Less observation Beds		392,500		0	392,500	201.00
202.00	Total (see instructions)		20,819,249	0	0	20,819,249	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Prepared: 11/27/2023 8:51 am
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		Title XIX			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,282,380		2,282,380		30.00
43.00	04300	NURSERY	857,979		857,979		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,208,433	5,576,783	6,785,216	0.225424	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,822,185	574,108	2,396,293	0.581072	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	525,645	24,382,059	24,907,704	0.159407	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	1,292,474	27,032,895	28,325,369	0.099126	60.00
65.00	06500	RESPIRATORY THERAPY	511,118	2,523,913	3,035,031	0.232018	65.00
65.01	03950	SLEEP LAB	0	1,014,506	1,014,506	0.190301	65.01
66.00	06600	PHYSICAL THERAPY	48,014	1,418,546	1,466,560	0.457303	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,514	209,347	234,861	0.082321	67.00
68.00	06800	SPEECH PATHOLOGY	1,611	132,789	134,400	0.305595	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	329,797	896,977	1,226,774	0.266628	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	59,835	59,835	0.517540	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	753,417	8,464,955	9,218,372	0.303345	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,381	787,784	791,165	0.306543	90.00
91.00	09100	EMERGENCY	313,845	21,009,578	21,323,423	0.156983	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	62,078	330,576	392,654	0.999608	92.00
200.00		Subtotal (see instructions)	10,037,871	94,414,651	104,452,522		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	10,037,871	94,414,651	104,452,522		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Prepared: 11/27/2023 8:51 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital
		11.00		Cost
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
65.01	03950 SLEEP LAB	0.000000		65.01
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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1301

Period:
From 07/01/2022
To 06/30/2023

Worksheet D
Part II
Date/Time Prepared:
11/27/2023 8:51 am

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	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	183,741	6,785,216	0.027080	7,624	206	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	77,408	2,396,293	0.032303	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	465,703	24,907,704	0.018697	97,188	1,817	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000 LABORATORY	103,475	28,325,369	0.003653	182,259	666	60.00
65.00	06500 RESPIRATORY THERAPY	54,003	3,035,031	0.017793	138,787	2,469	65.00
65.01	03950 SLEEP LAB	14,268	1,014,506	0.014064	0	0	65.01
66.00	06600 PHYSICAL THERAPY	73,486	1,466,560	0.050108	18,531	929	66.00
67.00	06700 OCCUPATIONAL THERAPY	6,441	234,861	0.027425	13,640	374	67.00
68.00	06800 SPEECH PATHOLOGY	956	134,400	0.007113	1,074	8	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	38,819	1,226,774	0.031643	76,025	2,406	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	689	59,835	0.011515	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	90,822	9,218,372	0.009852	134,646	1,327	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	5,864	791,165	0.007412	2,950	22	90.00
91.00	09100 EMERGENCY	164,598	21,323,423	0.007719	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	46,527	392,654	0.118494	0	0	92.00
200.00	Total (lines 50 through 199)	1,326,800	101,312,163		672,724	10,224	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Prepared: 11/27/2023 8:51 am
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Cost Center Description	Title XVIII			Hospital			
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	03950	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Prepared: 11/27/2023 8:51 am
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	Title XVIII		
						Hospital	Cost	
	4.00	5.00	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	6,785,216	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,396,293	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,907,704	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	28,325,369	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,035,031	0.000000	65.00
65.01	03950	SLEEP LAB	0	0	0	1,014,506	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	1,466,560	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	234,861	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	134,400	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,226,774	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	59,835	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,218,372	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	791,165	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	21,323,423	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	392,654	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	101,312,163		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Prepared: 11/27/2023 8:51 am
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Cost Center Description	Title XVIII			Hospital		Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
	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	7,624	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	97,188	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	182,259	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	138,787	0	0	0	65.00
65.01	03950	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	18,531	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	13,640	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,074	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	76,025	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	134,646	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	2,950	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		672,724	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part V Date/Time Prepared: 11/27/2023 8:51 am
		Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.225424	0	975,582	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.581072	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.159407	0	5,101,752	0	0	54.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000 LABORATORY	0.099126	0	4,446,763	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.232018	0	708,521	0	0	65.00
65.01	03950 SLEEP LAB	0.190301	0	8,892	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.457303	0	335,989	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.082321	0	71,362	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.305595	0	24,221	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266628	0	189,092	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.517540	0	7,550	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.303345	0	2,376,395	1,140	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.306543	0	261,794	893	0	90.00
91.00	09100 EMERGENCY	0.156983	0	2,897,924	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.999608	0	115,127	0	0	92.00
200.00	Subtotal (see instructions)		0	17,520,964	2,033	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	17,520,964	2,033	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part V Date/Time Prepared: 11/27/2023 8:51 am
		Title XVIII	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	219,920	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	813,255	0	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000 LABORATORY	440,790	0	60.00
65.00	06500 RESPIRATORY THERAPY	164,390	0	65.00
65.01	03950 SLEEP LAB	1,692	0	65.01
66.00	06600 PHYSICAL THERAPY	153,649	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	5,875	0	67.00
68.00	06800 SPEECH PATHOLOGY	7,402	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	50,417	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,907	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	720,868	346	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	80,251	274	90.00
91.00	09100 EMERGENCY	454,925	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	115,082	0	92.00
200.00	Subtotal (see instructions)	3,232,423	620	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	3,232,423	620	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-1301 Component CCN: 15-Z301	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part V Date/Time Prepared: 11/27/2023 8:51 am
Title XVIII			Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.225424	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.581072	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.159407	0	0	0	54.00
57.00	05700 CT SCAN	0.000000	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
60.00	06000 LABORATORY	0.099126	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.232018	0	0	0	65.00
65.01	03950 SLEEP LAB	0.190301	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.457303	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.082321	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.305595	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266628	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.517540	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.303345	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.306543	0	0	0	90.00
91.00	09100 EMERGENCY	0.156983	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.999608	0	0	0	92.00
200.00	Subtotal (see instructions)		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	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1301 Component CCN: 15-Z301	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part V Date/Time Prepared: 11/27/2023 8:51 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
65.01	03950	SLEEP LAB	0	0	65.01
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part III Date/Time Prepared: 11/27/2023 8:51 am
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Cost Center Description		Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
		1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00	
43.00	04300	NURSERY	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	200.00	
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
		4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	1,068	0.00	31 30.00	
43.00	04300	NURSERY	0	0	344	0.00	31 43.00	
200.00		Total (lines 30 through 199)	0	0	1,412		62 200.00	
Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
		9.00						
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0					30.00
43.00	04300	NURSERY	0					43.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1301

Period:
From 07/01/2022
To 06/30/2023

Worksheet D
Part IV
Date/Time Prepared:
11/27/2023 8:51 am

Cost Center Description	Title XIX			Hospital		Allied Health Cost	
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	03950	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Prepared: 11/27/2023 8:51 am
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Title XIX Hospital Cost				
				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	6,785,216	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,396,293	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,907,704	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	28,325,369	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,035,031	0.000000	65.00
65.01	03950	SLEEP LAB	0	0	0	1,014,506	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	1,466,560	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	234,861	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	134,400	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,226,774	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	59,835	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,218,372	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	791,165	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	21,323,423	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	392,654	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	101,312,163		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Prepared: 11/27/2023 8:51 am
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Cost Center Description	Title XIX			Hospital		Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
	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	173,747	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	233,077	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	46,999	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	125,126	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	19,047	0	0	0	65.00
65.01	03950	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	2,429	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	29,080	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	61,484	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	33,169	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		724,158	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/27/2023 8:51 am
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,095	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,068	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)		881	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		16	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		11	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)		225	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		250.44	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,277,994	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)		2,755	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)		36,338	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,241,656	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)		2,241,656	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)		2,098.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		472,259	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		472,259	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1301		Period: From 07/01/2022 To 06/30/2023		Worksheet D-1 Date/Time Prepared: 11/27/2023 8:51 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Hospital Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					139,422	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)					611,681	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)					187	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,098.93	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					392,500	89.00

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COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1301		Period: From 07/01/2022 To 06/30/2023		Worksheet D-1 Date/Time Prepared: 11/27/2023 8:51 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	270,030	2,277,994	0.118539	392,500	46,527	90.00
91.00	Nursing Program cost	0	2,277,994	0.000000	392,500	0	91.00
92.00	Allied health cost	0	2,277,994	0.000000	392,500	0	92.00
93.00	All other Medical Education	0	2,277,994	0.000000	392,500	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/27/2023 8:51 am
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,095	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,068	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)		881	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		16	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)		11	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		31	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)		344	15.00
16.00	Nursery days (title V or XIX only)		31	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		250.44	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,277,994	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)		2,755	25.00
26.00	Total swing-bed cost (see instructions)		36,338	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,241,656	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)		2,241,656	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)		2,098.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		65,067	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)		65,067	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/27/2023 8:51 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
42.00	NURSERY (title V & XIX only)	468,381	344	1,361.57	31	42,209
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					231,639
48.01	Program inpatient cellular therapy acquisition cost (worksheet D-6, Part III, line 10, column 1)					0
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					338,915
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
55.01	Permanent adjustment amount per discharge					0.00
55.02	Adjustment amount per discharge (contractor use only)					0.00
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					187
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,098.93
89.00	Observation bed cost (line 87 x line 88) (see instructions)					392,500

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COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1301		Period: From 07/01/2022 To 06/30/2023		Worksheet D-1 Date/Time Prepared: 11/27/2023 8:51 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	270,030	2,277,994	0.118539	392,500	46,527	90.00
91.00	Nursing Program cost	0	2,277,994	0.000000	392,500	0	91.00
92.00	Allied health cost	0	2,277,994	0.000000	392,500	0	92.00
93.00	All other Medical Education	0	2,277,994	0.000000	392,500	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet D-3 Date/Time Prepared: 11/27/2023 8:51 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		455,206	30.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.225424	7,624	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.581072	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159407	97,188	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
60.00	06000	LABORATORY	0.099126	182,259	60.00
65.00	06500	RESPIRATORY THERAPY	0.232018	138,787	65.00
65.01	03950	SLEEP LAB	0.190301	0	65.01
66.00	06600	PHYSICAL THERAPY	0.457303	18,531	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.082321	13,640	67.00
68.00	06800	SPEECH PATHOLOGY	0.305595	1,074	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266628	76,025	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.517540	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.303345	134,646	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.306543	2,950	90.00
91.00	09100	EMERGENCY	0.156983	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.999608	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		672,724	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)		672,724	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1301 Component CCN: 15-Z301	Period: From 07/01/2022 To 06/30/2023	Worksheet D-3 Date/Time Prepared: 11/27/2023 8:51 am
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.225424	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.581072	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.159407	0	0	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.099126	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.232018	0	0	65.00
65.01	03950 SLEEP LAB	0.190301	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.457303	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.082321	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.305595	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266628	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.517540	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.303345	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.306543	0	0	90.00
91.00	09100 EMERGENCY	0.156983	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.999608	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet D-3 Date/Time Prepared: 11/27/2023 8:51 am
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Cost Center Description		Ratio of Cost To Charges	Hospital 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		91,911		30.00
43.00	04300 NURSERY		83,452		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.225424	173,747	39,167	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.581072	233,077	135,435	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.159407	46,999	7,492	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.099126	125,126	12,403	60.00
65.00	06500 RESPIRATORY THERAPY	0.232018	19,047	4,419	65.00
65.01	03950 SLEEP LAB	0.190301	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.457303	2,429	1,111	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.082321	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.305595	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266628	29,080	7,754	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.517540	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.303345	61,484	18,651	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.306543	0	0	90.00
91.00	09100 EMERGENCY	0.156983	33,169	5,207	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.999608	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		724,158	231,639	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		724,158		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/27/2023 8:51 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,233,043	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)		3,233,043	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		3,265,373	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)		39,447	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,431,080	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)		794,846	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
28.50	REH facility payment amount		0	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)		794,846	30.00
31.00	Primary payer payments		294	31.00
32.00	Subtotal (line 30 minus line 31)		794,552	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)		503,950	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		327,568	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		394,718	36.00
37.00	Subtotal (see instructions)		1,122,120	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.75	N95 respirator payment adjustment amount (see instructions)		0	39.75
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,122,120	40.00
40.01	Sequestration adjustment (see instructions)		22,442	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		1,527,579	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-427,901	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		25,000	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time value of Money		0.00	92.00
93.00	Time value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/27/2023 8:51 am
		Title XVIII	Hospital Cost
			1.00
200.00	MEDICARE PART B ANCILLARY COSTS Part B Combined Billed Days		0 200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1301

Period:
From 07/01/2022
To 06/30/2023

Worksheet E-1
Part I
Date/Time Prepared:
11/27/2023 8:51 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		536,784		1,417,579	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	02/13/2023	41,300	02/13/2023	110,000	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)		41,300		110,000	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)		578,084		1,527,579	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		33,847		427,901	6.02	
7.00	Total Medicare program liability (see instructions)		544,237		1,099,678	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: 15-1301
Component CCN: 15-Z301

Period:
From 07/01/2022
To 06/30/2023

Worksheet E-1
Part I
Date/Time Prepared:
11/27/2023 8:51 am

		Title XVIII		Swing Beds - SNF		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		0		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)		0		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		0		0		6.02
7.00	Total Medicare program liability (see instructions)		0		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 - SWING BEDS		Provider CCN: 15-1301 Component CCN: 15-Z301	Period: From 07/01/2022 To 06/30/2023	Worksheet E-2 Date/Time Prepared: 11/27/2023 8:51 am
		Title XVIII	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		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)		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		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)		0	8.00
9.00	Primary payer payments (see instructions)		0	9.00
10.00	Subtotal (line 8 minus line 9)		0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	11.00
12.00	Subtotal (line 10 minus line 11)		0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	13.00
14.00	80% of Part B costs (line 12 x 80%)			14.00
15.00	Subtotal (see instructions)		0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		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	16.99
17.00	Allowable bad debts (see instructions)		0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	18.00
19.00	Total (see instructions)		0	19.00
19.01	Sequestration adjustment (see instructions)		0	19.01
19.02	Demonstration payment adjustment amount after sequestration		0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	19.25
20.00	Interim payments		0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)		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)		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	23.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part V Date/Time Prepared: 11/27/2023 8:51 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		611,681	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)		611,681	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		617,798	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)		617,798	19.00
20.00	Deductibles (exclude professional component)		72,676	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		545,122	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		545,122	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		15,726	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		10,222	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		9,380	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		555,344	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)		555,344	30.00
30.01	Sequestration adjustment (see instructions)		11,107	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM			30.03
31.00	Interim payments		578,084	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)		-33,847	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: 15-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 11/27/2023 8:51 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		338,915		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)		338,915	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)		338,915	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		91,911		8.00
9.00	Ancillary service charges		724,158	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)		816,069	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)		816,069	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		477,154	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)		338,915	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)		338,915	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)		338,915	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinsurance		0		33.00
34.00	Allowable bad debts (see instructions)		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)		338,915	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		338,915	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)		338,915	0	40.00
41.00	Interim payments		338,915	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		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: 15-1301

Period:
From 07/01/2022
To 06/30/2023

Worksheet G

Date/Time Prepared:
11/27/2023 8:51 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	475	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	9,035,831	0	0	0	4.00
5.00	Other receivable	1,434,738	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,796,334	0	0	0	6.00
7.00	Inventory	311,671	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,986,381	0	0	0	11.00
FIXED ASSETS						
12.00	Land	696,652	0	0	0	12.00
13.00	Land improvements	451,204	0	0	0	13.00
14.00	Accumulated depreciation	-106,636	0	0	0	14.00
15.00	Buildings	19,438,240	0	0	0	15.00
16.00	Accumulated depreciation	-13,222,146	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	1,786,208	0	0	0	19.00
20.00	Accumulated depreciation	-921,776	0	0	0	20.00
21.00	Automobiles and trucks	12,322	0	0	0	21.00
22.00	Accumulated depreciation	-12,322	0	0	0	22.00
23.00	Major movable equipment	8,046,858	0	0	0	23.00
24.00	Accumulated depreciation	-6,934,540	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)	9,234,064	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	34,895	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	34,895	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	13,255,340	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	608,860	0	0	0	37.00
38.00	Salaries, wages, and fees payable	409,773	0	0	0	38.00
39.00	Payroll taxes payable	19,383	0	0	0	39.00
40.00	Notes and loans payable (short term)	205,638	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,129,623	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,373,277	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	12,277,589	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	31,961	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	12,309,550	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,682,827	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-4,427,487				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-4,427,487	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	13,255,340	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1301

Period:
From 07/01/2022
To 06/30/2023

Worksheet G-1

Date/Time Prepared:
11/27/2023 8:51 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-5,020,107			0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,535,223				2.00
3.00	Total (sum of line 1 and line 2)		515,116			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00	Contributions/Donations/Grant Revenue	222,863		0		0	6.00
7.00		0		0		0	7.00
8.00	Other	615,025		0		0	8.00
9.00	Rounding	0		0		0	9.00
10.00	Total additions (sum of line 4-9)		837,888			0	10.00
11.00	Subtotal (line 3 plus line 10)		1,353,004			0	11.00
12.00	Transfer from Affiliates	5,793,425		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00	Released Capital	-12,935		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		5,780,490			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-4,427,486			0	19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00	Contributions/Donations/Grant Revenue		0				6.00
7.00			0				7.00
8.00	Other		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			0				14.00
15.00			0				15.00
16.00	Released Capital		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: 15-1301

Period:
From 07/01/2022
To 06/30/2023

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/27/2023 8:51 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	5,881,598		5,881,598	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)	5,881,598		5,881,598	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,881,598		5,881,598	17.00
18.00	Ancillary services	4,696,023	71,367,659	76,063,682	18.00
19.00	Outpatient services	376,717	22,130,522	22,507,239	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	10,954,338	93,498,181	104,452,519	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		24,596,382		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)		24,596,382		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-1301

Period:
From 07/01/2022
To 06/30/2023

Worksheet G-3

Date/Time Prepared:
11/27/2023 8:51 am

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	104,452,519	1.00
2.00	Less contractual allowances and discounts on patients' accounts	74,237,004	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,215,515	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	24,596,382	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,619,133	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	3,069	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	47,014	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	521	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	388,694	22.00
23.00	Governmental appropriations	0	23.00
24.00	Other Revenue	-554,832	24.00
24.05	Lab Services	1,541	24.05
24.50	COVID-19 PHE Funding	30,083	24.50
25.00	Total other income (sum of lines 6-24)	-83,910	25.00
26.00	Total (line 5 plus line 25)	5,535,223	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)	5,535,223	29.00