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: 15-0075	Period: From 10/01/2022 To 09/30/2023	Worksheet S Parts I-III Date/Time Prepared: 2/29/2024 5:11 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/29/2024 Time: 5:11 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by BLUFFTON REGIONAL MEDICAL CENTER (15-0075) for the cost reporting period beginning 10/01/2022 and ending 09/30/2023 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 have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title	VICE PRESIDENT			3
4	Date				4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	107,307	15,086	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	107,307	15,086	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: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/29/2024 5:11 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 303 S. MAIN STREET	PO Box:			1.00
2.00	City: BLUFFTON	State: IN	Zip Code: 46714-	County: WELLS	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	BLUFFTON REGIONAL MEDICAL CENTER	150075	99915	1	07/01/1966	N	P	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	BLUFFTON REGIONAL MEDICAL CENTER	15U075	23060		01/15/2020	N	P	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)	10/01/2022	09/30/2023	20.00
21.00	Type of Control (see instructions)	4		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/29/2024 5:11 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	85	32	0	2	634	31	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0075	Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part I Date/Time Prepared: 2/29/2024 5:11 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/29/2024 5:11 pm

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0075	Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part I Date/Time Prepared: 2/29/2024 5:11 pm

		1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)		
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?		68.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
		1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.	N	0	88.00

		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00		0	89.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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

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		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?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/29/2024 5:11 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	235,446	8,172	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y		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	HB1848	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: CHS / COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WPS	Contractor's Number: 10301	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	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: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/29/2024 5:11 pm

					1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
					1.00	
	Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00

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

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		9.99	169.00
		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/29/2024 5:11 pm

		Y/N	Date	
		1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE			
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y	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	01/22/2024	Y	01/22/2024	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/29/2024 5:11 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	Y	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.	N	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.	Y	12/31/2022	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.	KUZIWA	TSIGA	41.00
42.00	Enter the employer/company name of the cost report preparer.	CHS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-3416	KUZIWA_TSIGA@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0075	Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part II Date/Time Prepared: 2/29/2024 5:11 pm

		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.	SENIOR 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: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 2/29/2024 5:11 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	36	13,140	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		36	13,140	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	9	3,285	0.00	0	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)		45	16,425	0.00	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)		45				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: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/29/2024 5:11 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	653	62	2,456			1.00
2.00	HMO and other (see instructions)	782	471				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	500	0	1,150			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,153	62	3,606			7.00
8.00	INTENSIVE CARE UNIT	13	0	49			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		220	374			13.00
14.00	Total (see instructions)	1,166	282	4,029	0.00	170.83	14.00
15.00	CAH visits	0	0	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)			8			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	170.83	27.00
28.00	Observation Bed Days		0	709			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			53			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	31	66			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/29/2024 5:11 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	216	213	938	1.00
2.00	HMO and other (see instructions)			244	0		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	216	213	938	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 WAGE INDEX INFORMATION | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part II Date/Time Prepared: 2/29/2024 5:11 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	13,289,227	0	13,289,227	355,336.00	37.40	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,253,865	0	1,253,865	11,849.00	105.82	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		112,136	0	112,136	894.00	125.43	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		1,586,595	0	1,586,595	40,979.00	38.72	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		3,989,995	0	3,989,995			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		0	0	0			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		362,751	0	362,751			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part II | Date/Time Prepared: 2/29/2024 5:11 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	107,432	0	107,432	2,102.00	51.11	26.00
27.00	Administrative & General	5.00	1,516,435	-268,672	1,247,763	50,245.00	24.83	27.00
28.00	Administrative & General under contract (see inst.)		60,435	0	60,435	128.85	469.03	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	405,302	0	405,302	12,982.00	31.22	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	243,199	0	243,199	14,495.00	16.78	32.00
33.00	Housekeeping under contract (see instructions)		2,994	0	2,994	48.50	61.73	33.00
34.00	Dietary	10.00	932	-744	188	5.06	37.15	34.00
35.00	Dietary under contract (see instructions)		764,400	0	764,400	48,318.58	15.82	35.00
36.00	Cafeteria	11.00	0	744	744	19.94	37.31	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	782,573	268,672	1,051,245	23,891.00	44.00	38.00
39.00	Central Services and Supply	14.00	179,426	0	179,426	7,960.00	22.54	39.00
40.00	Pharmacy	15.00	583,414	0	583,414	11,547.00	50.53	40.00
41.00	Medical Records & Medical Records Library	16.00	141,458	0	141,458	5,113.00	27.67	41.00
42.00	Social Service	17.00	237,227	0	237,227	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part III Date/Time Prepared: 2/29/2024 5:11 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		14,117,056	0	14,117,056	403,831.93	34.96	1.00
2.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		14,117,056	0	14,117,056	403,831.93	34.96	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,952,596	0	2,952,596	53,722.00	54.96	4.00
5.00	Subtotal wage-related costs (see inst.)		4,352,746	0	4,352,746	0.00	30.83	5.00
6.00	Total (sum of lines 3 thru 5)		21,422,398	0	21,422,398	457,553.93	46.82	6.00
7.00	Total overhead cost (see instructions)		5,025,227	0	5,025,227	176,855.93	28.41	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part IV | Date/Time Prepared: 2/29/2024 5:11 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	310,038	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	2,451,956	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	4,345	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	27,557	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-116	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	6,060	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	213,245	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	769,598	17.00
18.00	Medicare Taxes - Employers Portion Only	179,987	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	27,328	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,989,998	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part V | Date/Time Prepared: 2/29/2024 5:11 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,253,865	3,989,998	1.00
2.00	Hospital	1,253,865	3,989,998	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0075	Period: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/29/2024 5:11 pm

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.158399	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,652,705	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	48,275,960	6.00
7.00	Medicaid cost (line 1 times line 6)	7,646,864	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	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 (see instructions)	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 (see instructions)	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 cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	2,595,358	4,681	2,600,039	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	411,102	4,681	415,783	21.00
22.00	Payments received from patients for amounts previously written off as charity care	70	0	70	22.00
23.00	Cost of charity care (see instructions)	411,032	4,681	415,713	23.00

		1.00	
24.00	Does the amount on line 20 col. 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
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	1,007,393	26.00
27.00	Medicare reimbursable bad debts (see instructions)	23,928	27.00
27.01	Medicare allowable bad debts (see instructions)	36,813	27.01
28.00	Non-Medicare bad debt amount (see instructions)	970,580	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	166,624	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	582,337	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	582,337	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 2/29/2024 5:11 pm

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.158399	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		5.00
6.00	Medicaid charges		6.00
7.00	Medicaid cost (line 1 times line 6)		7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP		9.00
10.00	Stand-alone CHIP charges		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		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)		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		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		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	2,595,358	4,681	2,600,039	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	411,102	4,681	415,783	21.00
22.00	Payments received from patients for amounts previously written off as charity care	70	0	70	22.00
23.00	Cost of charity care (see instructions)	411,032	4,681	415,713	23.00

		1.00	
24.00	Does the amount on line 20 col. 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
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	1,007,393	26.00
27.00	Medicare reimbursable bad debts (see instructions)	23,928	27.00
27.01	Medicare allowable bad debts (see instructions)	36,813	27.01
28.00	Non-Medicare bad debt amount (see instructions)	970,580	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	166,624	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	582,337	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	582,337	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/29/2024 5:11 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,028,107	1,028,107	771,215	1,799,322	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,518,796	1,518,796	63,831	1,582,627	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	107,432	68,970	176,402	3,125,616	3,302,018	4.00
5.01	01160	COMMUNICATIONS	0	0	0	561,244	561,244	5.01
5.02	00540	ADMITTING	0	0	0	705,085	705,085	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	765,602	765,602	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	1,516,435	12,729,883	14,246,318	-5,941,715	8,304,603	5.04
7.00	00700	OPERATION OF PLANT	405,302	1,440,086	1,845,388	498,493	2,343,881	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	137,760	137,760	0	137,760	8.00
9.00	00900	HOUSEKEEPING	243,199	124,164	367,363	-8,249	359,114	9.00
10.00	01000	DIETARY	932	955,982	956,914	-768,614	188,300	10.00
11.00	01100	CAFETERIA	0	0	0	763,308	763,308	11.00
13.00	01300	NURSING ADMINISTRATION	782,573	152,826	935,399	268,435	1,203,834	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	179,426	250,235	429,661	-36,040	393,621	14.00
15.00	01500	PHARMACY	583,414	1,182,515	1,765,929	-1,033,709	732,220	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	141,458	395,136	536,594	-269	536,325	16.00
17.00	01700	SOCIAL SERVICE	237,227	67,932	305,159	0	305,159	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,318,961	2,035,483	4,354,444	-1,177,981	3,176,463	30.00
31.00	03100	INTENSIVE CARE UNIT	166,112	13,834	179,946	-274	179,672	31.00
43.00	04300	NURSERY	0	0	0	541,759	541,759	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,279,406	2,600,022	3,879,428	-786,322	3,093,106	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	615,410	615,410	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,129,506	590,607	1,720,113	-213,089	1,507,024	54.00
56.00	05600	RADIOISOTOPE	42,894	64,127	107,021	-329	106,692	56.00
60.00	06000	LABORATORY	1,158,365	1,080,973	2,239,338	-94,232	2,145,106	60.00
65.00	06500	RESPIRATORY THERAPY	382,224	52,496	434,720	-3,845	430,875	65.00
66.00	06600	PHYSICAL THERAPY	565,682	61,683	627,365	-174	627,191	66.00
67.00	06700	OCCUPATIONAL THERAPY	378,506	35,925	414,431	-4,000	410,431	67.00
68.00	06800	SPEECH PATHOLOGY	194,530	16,325	210,855	0	210,855	68.00
69.00	06900	ELECTROCARDIOLOGY	187,292	24,548	211,840	0	211,840	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	324,367	324,367	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	195,565	195,565	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	872,672	872,672	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	19,272	6,507	25,779	0	25,779	76.01
76.03	03953	WOUND CARE	59,755	29,011	88,766	-1,490	87,276	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,209,324	1,730,785	2,940,109	-2,270	2,937,839	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)	13,289,227	28,394,718	41,683,945	0	41,683,945	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	13,289,227	28,394,718	41,683,945	0	41,683,945	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/29/2024 5:11 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-78,514	1,720,808		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	75,136	1,657,763		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,302,018		4.00
5.01	01160	COMMUNICATIONS	0	561,244		5.01
5.02	00540	ADMITTING	0	705,085		5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	765,602		5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	-3,746,029	4,558,574		5.04
7.00	00700	OPERATION OF PLANT	-5,255	2,338,626		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	137,760		8.00
9.00	00900	HOUSEKEEPING	0	359,114		9.00
10.00	01000	DIETARY	0	188,300		10.00
11.00	01100	CAFETERIA	0	763,308		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,203,834		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	393,621		14.00
15.00	01500	PHARMACY	0	732,220		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-96	536,229		16.00
17.00	01700	SOCIAL SERVICE	0	305,159		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-941,952	2,234,511		30.00
31.00	03100	INTENSIVE CARE UNIT	0	179,672		31.00
43.00	04300	NURSERY	0	541,759		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-129,500	2,963,606		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	615,410		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-154,453	1,352,571		54.00
56.00	05600	RADIOISOTOPE	0	106,692		56.00
60.00	06000	LABORATORY	0	2,145,106		60.00
65.00	06500	RESPIRATORY THERAPY	0	430,875		65.00
66.00	06600	PHYSICAL THERAPY	0	627,191		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	410,431		67.00
68.00	06800	SPEECH PATHOLOGY	0	210,855		68.00
69.00	06900	ELECTROCARDIOLOGY	0	211,840		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	324,367		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	195,565		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	872,672		73.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	25,779		76.01
76.03	03953	WOUND CARE	0	87,276		76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,077,193	1,860,646		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)	-6,057,856	35,626,089		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,057,856	35,626,089		200.00

RECLASSIFICATIONS | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/29/2024 5:11 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,125,845	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	3,125,845	
	B - RECLASS RENTAL AND LEASE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	427,479	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	56,677	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
	TOTALS		0	484,156	
	C - RECLASS OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	159,227	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	182,994	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,154	3.00
	TOTALS		0	349,375	
	D - RECLASS REPAIRS & MAINTENANCE				
1.00	OPERATION OF PLANT	7.00	0	421,966	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	TOTALS		0	421,966	
	E - RECLASS CNO COSTS				
1.00	NURSING ADMINISTRATION	13.00	268,672	0	1.00
	TOTALS		268,672	0	
	F - RECLASS MEDICAL SUPPLIES				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	41,051	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	324,367	2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	195,565	3.00
	TOTALS		0	560,983	
	G - RECLASS COST OF DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	872,672	1.00
	TOTALS		0	872,672	
	H - RECLASS LABOR AND DELIVERY COSTS				
1.00	NURSERY	43.00	274,397	267,362	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	311,701	303,709	2.00
	TOTALS		586,098	571,071	
	I - RECLASS A PORTION OF DIETARY TO CAFE				
1.00	CAFETERIA	11.00	744	762,564	1.00
	TOTALS		744	762,564	
	J - RECLASS ADMIN AND GENERAL COSTS				
1.00	COMMUNICATIONS	5.01	99,989	461,255	1.00
2.00	ADMITTING	5.02	557,002	148,083	2.00
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.03	0	765,602	3.00
	TOTALS		656,991	1,374,940	

RECLASSIFICATIONS | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/29/2024 5:11 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	K - NON-CAPITALIZED EQUIPMENT					
1.00	OPERATION OF PLANT	7.00	0	88,403		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		0	88,403		
	L - INTEREST EXPENSE					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	646		1.00
	TOTALS		0	646		
	M - VARIABLE RENT EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	938		1.00
	TOTALS		0	938		
	N - FINANCIAL LEASE DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,223		1.00
	TOTALS		0	1,223		
500.00	Grand Total: Increases		1,512,505	8,614,782		500.00

RECLASSIFICATIONS | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/29/2024 5:11 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS EMPLOYEE BENEFITS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	3,125,769	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	76	0		2.00
	TOTALS		0	3,125,845			
	B - RECLASS RENTAL AND LEASE EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	229	10		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	1,078	10		2.00
3.00	OPERATION OF PLANT	7.00	0	11,876	0		3.00
4.00	DIETARY	10.00	0	227	10		4.00
5.00	NURSING ADMINISTRATION	13.00	0	46	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	49,110	0		6.00
7.00	PHARMACY	15.00	0	134,816	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	269	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	14,345	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	90	0		10.00
11.00	OPERATING ROOM	50.00	0	26,326	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	177,545	0		12.00
13.00	LABORATORY	60.00	0	66,353	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	84	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	174	0		15.00
16.00	WOUND CARE	76.03	0	1,434	0		16.00
17.00	EMERGENCY	91.00	0	154	0		17.00
	TOTALS		0	484,156			
	C - RECLASS OTHER CAPITAL COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	349,375	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	349,375			
	D - RECLASS REPAIRS & MAINTENANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	163,375	0		1.00
2.00	HOUSEKEEPING	9.00	0	8,249	0		2.00
3.00	DIETARY	10.00	0	5,079	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	115	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	27,480	0		5.00
6.00	PHARMACY	15.00	0	26,221	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	6,467	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	115	0		8.00
9.00	OPERATING ROOM	50.00	0	111,236	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	35,544	0		10.00
11.00	RADIOISOTOPE	56.00	0	329	0		11.00
12.00	LABORATORY	60.00	0	27,879	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	3,761	0		13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	4,000	0		14.00
15.00	EMERGENCY	91.00	0	2,116	0		15.00
	TOTALS		0	421,966			
	E - RECLASS CNO COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	268,672	0	0		1.00
	TOTALS		268,672	0			
	F - RECLASS MEDICAL SUPPLIES						
1.00	OPERATING ROOM	50.00	0	560,983	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	560,983			
	G - RECLASS COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	872,672	0		1.00
	TOTALS		0	872,672			
	H - RECLASS LABOR AND DELIVERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	586,098	571,071	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		586,098	571,071			
	I - RECLASS A PORTION OF DIETARY TO CAFE						
1.00	DIETARY	10.00	744	762,564	0		1.00
	TOTALS		744	762,564			
	J - RECLASS ADMIN AND GENERAL COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	656,991	1,374,940	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		656,991	1,374,940			

RECLASSIFICATIONS | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/29/2024 5:11 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	K - NON-CAPITALIZED EQUIPMENT						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	501	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	69	0		2.00
3.00	OPERATING ROOM	50.00	0	87,777	0		3.00
4.00	WOUND CARE	76.03	0	56	0		4.00
	TOTALS		0	88,403			
	L - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	646	11		1.00
	TOTALS		0	646			
	M - VARIABLE RENT EXPENSE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	938	10		1.00
	TOTALS		0	938			
	N - FINANCIAL LEASE DEPRECIATION						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	1,223	9		1.00
	TOTALS		0	1,223			
500.00	Grand Total: Decreases		1,512,505	8,614,782			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 2/29/2024 5:11 pm

		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	3,835,200	0	0	0	0	1.00
2.00	Land Improvements	682,792	0	0	0	0	2.00
3.00	Buildings and Fixtures	18,037,914	0	0	0	0	3.00
4.00	Building Improvements	8,111,192	185,404	0	185,404	0	4.00
5.00	Fixed Equipment	3,886,782	0	0	0	939,411	5.00
6.00	Movable Equipment	16,206,671	0	0	0	602,817	6.00
7.00	HIT designated Assets	2,102,798	0	0	0	1,156,881	7.00
8.00	Subtotal (sum of lines 1-7)	52,863,349	185,404	0	185,404	2,699,109	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	52,863,349	185,404	0	185,404	2,699,109	10.00

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,835,200	0				1.00
2.00	Land Improvements	682,792	0				2.00
3.00	Buildings and Fixtures	18,037,914	0				3.00
4.00	Building Improvements	8,296,596	0				4.00
5.00	Fixed Equipment	2,947,371	0				5.00
6.00	Movable Equipment	15,603,854	0				6.00
7.00	HIT designated Assets	945,917	0				7.00
8.00	Subtotal (sum of lines 1-7)	50,349,644	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	50,349,644	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 2/29/2024 5:11 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,028,107	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,518,796	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,546,903	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,028,107	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,518,796	2.00
3.00	Total (sum of lines 1-2)	0	2,546,903	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 2/29/2024 5:11 pm

	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	33,799,873	105,568	33,694,305	0.670613	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	16,549,770	0	16,549,770	0.329387	0	2.00
3.00	Total (sum of lines 1-2)	50,349,643	105,568	50,244,075	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	832,587	428,417	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,593,307	56,677	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,425,894	485,094	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	-646	159,227	182,994	118,229	1,720,808	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	7,154	0	625	1,657,763	2.00
3.00	Total (sum of lines 1-2)	-646	166,381	182,994	118,854	3,378,571	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/29/2024 5:11 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	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)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-5,255	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,326,409			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	-94,148			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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	B	-96	MEDICAL RECORDS & LIBRARY	16.00	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)	A	-5,580	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/29/2024 5:11 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	INSERVICE EDUCATION	B	-2,435	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.00
33.01	FITNESS REVENUE	B	-8,580	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.01
33.02	OTHER MISC REVENUE	B	-9,744	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.02
33.04	MARKETING EXPENSE	A	-3,800	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.04
33.05	PHYSICIAN RECRUITING	A	-8,808	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.05
33.06	CHARITABLE CONTRIBUTIONS	A	-32,199	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.06
33.07	CRNA COSTS	A	-762,960	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.07
33.08	LOBBYING EXPENSE	A	-4,382	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.08
33.09	PENALTIES/LATE FEES	A	-371	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.09
33.12	MARKETING DEPARTMENT	A	-55,536	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.12
33.13	PROVIDER TAX EXPENSE	A	-2,567,315	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.13
33.14	RENTAL INCOME	B	-232,222	CAP REL COSTS-BLDG & FIXT	1.00	9	33.14
33.15	ANTHEM SETTLMENT	B	61,984	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,057,856				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: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 2/29/2024 5:11 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL-RELATED INTEREST	115,239	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	2,990	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	625	0	3.00
4.00	5.04	OTHER ADMINISTRATIVE AND GEN	PASI OPERATING COSTS	213,570	168,839	4.00
4.01	5.04	OTHER ADMINISTRATIVE AND GEN	SHARED SERVICE CENTER ALLOCA	994,733	684,753	4.01
4.02	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	35,479	0	4.02
4.03	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	74,511	0	4.03
4.04	5.04	OTHER ADMINISTRATIVE AND GEN	NON-CAPITAL HOME OFFICE COST	1,386,849	0	4.04
4.05	5.04	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE COSTS	242,968	365,209	4.05
4.06	5.04	OTHER ADMINISTRATIVE AND GEN	MANAGEMENT FEES	0	836,983	4.06
4.07	5.04	OTHER ADMINISTRATIVE AND GEN	401K FEES	0	5,088	4.07
4.08	5.04	OTHER ADMINISTRATIVE AND GEN	AUDIT FEES	0	29,212	4.08
4.09	5.04	OTHER ADMINISTRATIVE AND GEN	CORPORATE OVERHEAD ALLOCATIO	0	629,480	4.09
4.10	5.04	OTHER ADMINISTRATIVE AND GEN	HIIM ALLOCATION	0	333,063	4.10
4.11	5.04	OTHER ADMINISTRATIVE AND GEN	CONTRACT MANAGEMENT	0	99,157	4.11
4.12	5.04	OTHER ADMINISTRATIVE AND GEN	PASI LIEN UNIT COLLECTION FE	0	9,328	4.12
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,066,964	3,161,112	5.00

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

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

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

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

6.00	B	CHS, INC.	100.00	CHS, INC.	100.00	6.00
7.00	B	PASI	100.00	PASI	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:					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: 15-0075	Period: From 10/01/2022 To 09/30/2023	Worksheet A-8-1 Date/Time Prepared: 2/29/2024 5:11 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	115,239	14		1.00
2.00	2,990	14		2.00
3.00	625	14		3.00
4.00	44,731	0		4.00
4.01	309,980	0		4.01
4.02	35,479	9		4.02
4.03	74,511	9		4.03
4.04	1,386,849	0		4.04
4.05	-122,241	0		4.05
4.06	-836,983	0		4.06
4.07	-5,088	0		4.07
4.08	-29,212	0		4.08
4.09	-629,480	0		4.09
4.10	-333,063	0		4.10
4.11	-99,157	0		4.11
4.12	-9,328	0		4.12
5.00	-94,148			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	HOSPITAL MANAGE		6.00
7.00	COLLECTIONS		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: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 2/29/2024 5:11 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	28,891	28,891	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	936,372	936,372	0	0	0	2.00
3.00	50.00	OPERATING ROOM	129,500	129,500	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	154,453	154,453	0	0	0	4.00
5.00	91.00	EMERGENCY	1,077,193	1,077,193	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			2,326,409	2,326,409	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	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	5.04	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	28,891		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	936,372		2.00
3.00	50.00	OPERATING ROOM	0	0	0	129,500		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	154,453		4.00
5.00	91.00	EMERGENCY	0	0	0	1,077,193		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	2,326,409		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/29/2024 5:11 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,720,808	1,720,808				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,657,763		1,657,763			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,302,018	6,483	6,245	3,314,746		4.00
5.01	01160	COMMUNICATIONS	561,244	3,973	3,827	25,144	594,188	5.01
5.02	00540	ADMITTING	705,085	7,334	7,065	140,066	23,854	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	765,602	10,136	9,765	0	17,349	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	4,558,574	173,134	166,791	148,558	112,765	5.04
7.00	00700	OPERATION OF PLANT	2,338,626	637,580	614,221	101,919	26,023	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	137,760	0	0	0	2,169	8.00
9.00	00900	HOUSEKEEPING	359,114	8,230	7,928	61,156	4,337	9.00
10.00	01000	DIETARY	188,300	46,780	45,066	47	19,517	10.00
11.00	01100	CAFETERIA	763,308	0	0	187	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,203,834	8,496	8,185	264,350	6,506	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	393,621	34,010	32,764	45,119	10,843	14.00
15.00	01500	PHARMACY	732,220	14,473	13,943	146,708	23,854	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	536,229	55,480	53,447	35,572	54,214	16.00
17.00	01700	SOCIAL SERVICE	305,159	1,508	1,452	59,654	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,234,511	324,160	312,284	435,751	43,371	30.00
31.00	03100	INTENSIVE CARE UNIT	179,672	19,253	18,548	41,771	10,843	31.00
43.00	04300	NURSERY	541,759	0	0	69,001	2,169	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,963,606	118,435	114,096	321,725	73,731	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	615,410	0	0	78,382	4,337	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,352,571	96,265	92,738	284,030	45,540	54.00
56.00	05600	RADIOISOTOPE	106,692	5,099	4,912	10,786	4,337	56.00
60.00	06000	LABORATORY	2,145,106	39,410	37,967	291,287	41,203	60.00
65.00	06500	RESPIRATORY THERAPY	430,875	6,820	6,570	96,116	6,506	65.00
66.00	06600	PHYSICAL THERAPY	627,191	53,076	51,132	142,249	10,843	66.00
67.00	06700	OCCUPATIONAL THERAPY	410,431	0	0	95,181	0	67.00
68.00	06800	SPEECH PATHOLOGY	210,855	0	0	48,917	0	68.00
69.00	06900	ELECTROCARDIOLOGY	211,840	4,860	4,682	47,097	13,011	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	324,367	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	195,565	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	872,672	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	25,779	4,842	4,665	4,846	0	76.01
76.03	03953	WOUND CARE	87,276	0	0	15,026	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,860,646	40,971	39,470	304,101	36,866	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)	35,626,089	1,720,808	1,657,763	3,314,746	594,188	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	35,626,089	1,720,808	1,657,763	3,314,746	594,188	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/29/2024 5:11 pm

		Cost Center Description	Subtotal	ADMITTING	Subtotal	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5A.01	5.02	5A.02	5.03	5A.03	
		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
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING	883,404	883,404				5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	802,852	20,414	823,266	823,266		5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	5,159,822	131,203	5,291,025	125,165	5,416,190	5.04
7.00	00700	OPERATION OF PLANT	3,718,369	94,547	3,812,916	90,195	3,903,111	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	139,929	3,558	143,487	3,394	146,881	8.00
9.00	00900	HOUSEKEEPING	440,765	11,207	451,972	10,691	462,663	9.00
10.00	01000	DIETARY	299,710	7,621	307,331	7,270	314,601	10.00
11.00	01100	CAFETERIA	763,495	19,413	782,908	18,520	801,428	11.00
13.00	01300	NURSING ADMINISTRATION	1,491,371	37,921	1,529,292	36,175	1,565,467	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	516,357	13,129	529,486	12,525	542,011	14.00
15.00	01500	PHARMACY	931,198	23,678	954,876	22,588	977,464	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	734,942	18,687	753,629	17,827	771,456	16.00
17.00	01700	SOCIAL SERVICE	367,773	9,351	377,124	8,921	386,045	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,350,077	85,182	3,435,259	81,261	3,516,520	30.00
31.00	03100	INTENSIVE CARE UNIT	270,087	6,868	276,955	6,551	283,506	31.00
43.00	04300	NURSERY	612,929	15,585	628,514	14,867	643,381	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,591,593	91,323	3,682,916	87,119	3,770,035	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	698,129	17,751	715,880	16,934	732,814	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,871,144	47,578	1,918,722	45,387	1,964,109	54.00
56.00	05600	RADIOISOTOPE	131,826	3,352	135,178	3,198	138,376	56.00
60.00	06000	LABORATORY	2,554,973	64,965	2,619,938	61,975	2,681,913	60.00
65.00	06500	RESPIRATORY THERAPY	546,887	13,906	560,793	13,266	574,059	65.00
66.00	06600	PHYSICAL THERAPY	884,491	22,490	906,981	21,455	928,436	66.00
67.00	06700	OCCUPATIONAL THERAPY	505,612	12,856	518,468	12,264	530,732	67.00
68.00	06800	SPEECH PATHOLOGY	259,772	6,605	266,377	6,301	272,678	68.00
69.00	06900	ELECTROCARDIOLOGY	281,490	7,157	288,647	6,828	295,475	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	324,367	8,248	332,615	7,868	340,483	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	195,565	4,973	200,538	4,744	205,282	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	872,672	22,189	894,861	21,168	916,029	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	40,132	1,020	41,152	973	42,125	76.01
76.03	03953	WOUND CARE	102,302	2,601	104,903	2,481	107,384	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,282,054	58,026	2,340,080	55,355	2,395,435	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,626,089	883,404	35,626,089	823,266	35,626,089	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments	0		0		0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	35,626,089	883,404	35,626,089	823,266	35,626,089	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/29/2024 5:11 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.04	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
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	5,416,190					5.04
7.00	00700	OPERATION OF PLANT	699,778	4,602,889				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,334	0	173,215			8.00
9.00	00900	HOUSEKEEPING	82,949	42,940	0	588,552		9.00
10.00	01000	DIETARY	56,403	244,084	0	31,504	646,592	10.00
11.00	01100	CAFETERIA	143,684	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	280,665	44,328	0	5,721	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	97,174	177,452	0	22,904	0	14.00
15.00	01500	PHARMACY	175,245	75,516	0	9,747	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	138,310	289,476	0	37,363	0	16.00
17.00	01700	SOCIAL SERVICE	69,212	7,866	0	1,015	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	630,459	1,691,375	57,029	218,305	646,592	30.00
31.00	03100	INTENSIVE CARE UNIT	50,828	100,456	575	12,966	0	31.00
43.00	04300	NURSERY	115,349	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	675,911	617,960	35,529	79,760	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	131,383	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	352,135	502,281	26,949	64,829	0	54.00
56.00	05600	RADIOISOTOPE	24,809	26,606	0	3,434	0	56.00
60.00	06000	LABORATORY	480,827	205,632	0	26,541	0	60.00
65.00	06500	RESPIRATORY THERAPY	102,920	35,583	527	4,593	0	65.00
66.00	06600	PHYSICAL THERAPY	166,455	276,937	348	35,744	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	95,152	0	4,376	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	48,887	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	52,974	25,357	0	3,273	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	61,043	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,804	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	164,230	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	7,552	25,264	0	3,261	0	76.01
76.03	03953	WOUND CARE	19,252	0	1,837	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	429,466	213,776	46,045	27,592	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,416,190	4,602,889	173,215	588,552	646,592	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,416,190	4,602,889	173,215	588,552	646,592	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/29/2024 5:11 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	945,112					11.00
13.00	01300	NURSING ADMINISTRATION	64,144	1,960,325				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27,327	0	866,868			14.00
15.00	01500	PHARMACY	39,600	0	0	1,277,572		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,552	0	702	0	1,254,859	16.00
17.00	01700	SOCIAL SERVICE	17,766	0	372	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	147,839	954,255	61,475	0	66,169	30.00
31.00	03100	INTENSIVE CARE UNIT	10,845	56,395	9	0	1,900	31.00
43.00	04300	NURSERY	23,332	429,798	0	0	4,460	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	100,248	0	240,966	0	198,626	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,339	0	0	0	3,133	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	100,105	0	20,692	0	264,939	54.00
56.00	05600	RADIOISOTOPE	4,138	0	16,432	0	5,433	56.00
60.00	06000	LABORATORY	136,637	108	230,964	0	273,078	60.00
65.00	06500	RESPIRATORY THERAPY	30,824	0	9,102	0	14,936	65.00
66.00	06600	PHYSICAL THERAPY	54,441	0	6,919	0	28,898	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,535	0	1,424	0	22,457	67.00
68.00	06800	SPEECH PATHOLOGY	15,198	0	1,037	0	8,480	68.00
69.00	06900	ELECTROCARDIOLOGY	19,122	0	1,068	0	44,983	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	137,019	0	67,927	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	88,624	0	19,194	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,277,572	84,709	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	1,641	0	1,601	0	1,757	76.01
76.03	03953	WOUND CARE	5,922	26,690	8,064	0	5,491	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	78,557	493,079	40,398	0	138,289	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)	945,112	1,960,325	866,868	1,277,572	1,254,859	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	945,112	1,960,325	866,868	1,277,572	1,254,859	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/29/2024 5:11 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	482,276					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	411,417	8,401,435	0	8,401,435		30.00
31.00	03100	INTENSIVE CARE UNIT	8,208	525,688	0	525,688		31.00
43.00	04300	NURSERY	62,651	1,278,971	0	1,278,971		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,719,035	0	5,719,035		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	883,669	0	883,669		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,296,039	0	3,296,039		54.00
56.00	05600	RADIOISOTOPE	0	219,228	0	219,228		56.00
60.00	06000	LABORATORY	0	4,035,700	0	4,035,700		60.00
65.00	06500	RESPIRATORY THERAPY	0	772,544	0	772,544		65.00
66.00	06600	PHYSICAL THERAPY	0	1,498,178	0	1,498,178		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	687,676	0	687,676		67.00
68.00	06800	SPEECH PATHOLOGY	0	346,280	0	346,280		68.00
69.00	06900	ELECTROCARDIOLOGY	0	442,252	0	442,252		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	606,472	0	606,472		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	349,904	0	349,904		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,442,540	0	2,442,540		73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0		76.00
76.01	03951	SLEEP LAB	0	83,201	0	83,201		76.01
76.03	03953	WOUND CARE	0	174,640	0	174,640		76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	3,862,637	0	3,862,637		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)	482,276	35,626,089	0	35,626,089		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	482,276	35,626,089	0	35,626,089		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/29/2024 5:11 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,483	6,245	12,728	12,728	4.00
5.01	01160	COMMUNICATIONS	0	3,973	3,827	7,800	97	5.01
5.02	00540	ADMITTING	0	7,334	7,065	14,399	538	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	10,136	9,765	19,901	0	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	0	173,134	166,791	339,925	571	5.04
7.00	00700	OPERATION OF PLANT	0	637,580	614,221	1,251,801	392	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	8,230	7,928	16,158	235	9.00
10.00	01000	DIETARY	0	46,780	45,066	91,846	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	1	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,496	8,185	16,681	1,016	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	34,010	32,764	66,774	173	14.00
15.00	01500	PHARMACY	0	14,473	13,943	28,416	564	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	55,480	53,447	108,927	137	16.00
17.00	01700	SOCIAL SERVICE	0	1,508	1,452	2,960	229	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	324,160	312,284	636,444	1,667	30.00
31.00	03100	INTENSIVE CARE UNIT	0	19,253	18,548	37,801	160	31.00
43.00	04300	NURSERY	0	0	0	0	265	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	118,435	114,096	232,531	1,236	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	301	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	96,265	92,738	189,003	1,091	54.00
56.00	05600	RADIOISOTOPE	0	5,099	4,912	10,011	41	56.00
60.00	06000	LABORATORY	0	39,410	37,967	77,377	1,119	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,820	6,570	13,390	369	65.00
66.00	06600	PHYSICAL THERAPY	0	53,076	51,132	104,208	546	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	366	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	188	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,860	4,682	9,542	181	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	4,842	4,665	9,507	19	76.01
76.03	03953	WOUND CARE	0	0	0	0	58	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	40,971	39,470	80,441	1,168	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)	0	1,720,808	1,657,763	3,378,571	12,728	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,720,808	1,657,763	3,378,571	12,728	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/29/2024 5:11 pm

		Cost Center Description	COMMUNICATIONS	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	
			5.01	5.02	5.03	5.04	7.00	
		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
5.01	01160	COMMUNICATIONS	7,897					5.01
5.02	00540	ADMITTING	317	15,254				5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	231	352	20,484			5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	1,498	2,267	3,103	347,364		5.04
7.00	00700	OPERATION OF PLANT	346	1,632	2,246	44,887	1,301,304	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	29	61	85	1,689	0	8.00
9.00	00900	HOUSEKEEPING	58	193	266	5,320	12,140	9.00
10.00	01000	DIETARY	259	132	181	3,617	69,006	10.00
11.00	01100	CAFETERIA	0	335	461	9,215	0	11.00
13.00	01300	NURSING ADMINISTRATION	86	655	901	18,000	12,532	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	144	227	312	6,232	50,168	14.00
15.00	01500	PHARMACY	317	409	562	11,239	21,349	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	721	323	444	8,870	81,839	16.00
17.00	01700	SOCIAL SERVICE	0	161	222	4,439	2,224	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	576	1,471	2,023	40,433	478,177	30.00
31.00	03100	INTENSIVE CARE UNIT	144	119	163	3,260	28,400	31.00
43.00	04300	NURSERY	29	269	370	7,398	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	980	1,577	2,169	43,348	174,706	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	58	306	422	8,426	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	605	821	1,130	22,583	142,002	54.00
56.00	05600	RADIOISOTOPE	58	58	80	1,591	7,522	56.00
60.00	06000	LABORATORY	548	1,122	1,543	30,837	58,135	60.00
65.00	06500	RESPIRATORY THERAPY	86	240	330	6,601	10,060	65.00
66.00	06600	PHYSICAL THERAPY	144	388	534	10,675	78,294	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	222	305	6,102	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	114	157	3,135	0	68.00
69.00	06900	ELECTROCARDIOLOGY	173	124	170	3,397	7,169	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	142	196	3,915	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	86	118	2,360	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	383	527	10,533	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	18	24	484	7,143	76.01
76.03	03953	WOUND CARE	0	45	62	1,235	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	490	1,002	1,378	27,543	60,438	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)	7,897	15,254	20,484	347,364	1,301,304	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	7,897	15,254	20,484	347,364	1,301,304	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/29/2024 5:11 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		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
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,864					8.00
9.00	00900	HOUSEKEEPING	0	34,370				9.00
10.00	01000	DIETARY	0	1,840	166,881			10.00
11.00	01100	CAFETERIA	0	0	0	10,012		11.00
13.00	01300	NURSING ADMINISTRATION	0	334	0	680	50,885	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,338	0	289	0	14.00
15.00	01500	PHARMACY	0	569	0	419	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,182	0	186	0	16.00
17.00	01700	SOCIAL SERVICE	0	59	0	188	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	613	12,749	166,881	1,567	24,769	30.00
31.00	03100	INTENSIVE CARE UNIT	6	757	0	115	1,464	31.00
43.00	04300	NURSERY	0	0	0	247	11,157	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	382	4,658	0	1,062	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	173	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	290	3,786	0	1,060	0	54.00
56.00	05600	RADIOISOTOPE	0	201	0	44	0	56.00
60.00	06000	LABORATORY	0	1,550	0	1,447	3	60.00
65.00	06500	RESPIRATORY THERAPY	6	268	0	327	0	65.00
66.00	06600	PHYSICAL THERAPY	4	2,087	0	577	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	47	0	0	355	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	161	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	191	0	203	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	190	0	17	0	76.01
76.03	03953	WOUND CARE	20	0	0	63	693	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	496	1,611	0	832	12,799	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)	1,864	34,370	166,881	10,012	50,885	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,864	34,370	166,881	10,012	50,885	202.00

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		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		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
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	125,657					14.00
15.00	01500	PHARMACY	0	63,844				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	102	0	203,731			16.00
17.00	01700	SOCIAL SERVICE	54	0	0	10,536		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,911	0	10,746	8,988	1,396,015	30.00
31.00	03100	INTENSIVE CARE UNIT	1	0	309	179	72,878	31.00
43.00	04300	NURSERY	0	0	724	1,369	21,828	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	34,929	0	32,256	0	529,834	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	509	0	10,195	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,999	0	43,025	0	408,395	54.00
56.00	05600	RADIOISOTOPE	2,382	0	882	0	22,870	56.00
60.00	06000	LABORATORY	33,480	0	44,295	0	251,456	60.00
65.00	06500	RESPIRATORY THERAPY	1,319	0	2,425	0	35,421	65.00
66.00	06600	PHYSICAL THERAPY	1,003	0	4,693	0	203,153	66.00
67.00	06700	OCCUPATIONAL THERAPY	206	0	3,647	0	11,250	67.00
68.00	06800	SPEECH PATHOLOGY	150	0	1,377	0	5,282	68.00
69.00	06900	ELECTROCARDIOLOGY	155	0	7,305	0	28,610	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,862	0	11,031	0	35,146	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,847	0	3,117	0	18,528	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	63,844	13,756	0	89,043	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	232	0	285	0	17,919	76.01
76.03	03953	WOUND CARE	1,169	0	892	0	4,237	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,856	0	22,457	0	216,511	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)	125,657	63,844	203,731	10,536	3,378,571	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	125,657	63,844	203,731	10,536	3,378,571	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/29/2024 5:11 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
5.01	01160	COMMUNICATIONS				5.01
5.02	00540	ADMITTING				5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL				5.04
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,396,015		30.00
31.00	03100	INTENSIVE CARE UNIT	0	72,878		31.00
43.00	04300	NURSERY	0	21,828		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	529,834		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	10,195		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	408,395		54.00
56.00	05600	RADIOISOTOPE	0	22,870		56.00
60.00	06000	LABORATORY	0	251,456		60.00
65.00	06500	RESPIRATORY THERAPY	0	35,421		65.00
66.00	06600	PHYSICAL THERAPY	0	203,153		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,250		67.00
68.00	06800	SPEECH PATHOLOGY	0	5,282		68.00
69.00	06900	ELECTROCARDIOLOGY	0	28,610		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	35,146		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,528		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	89,043		73.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	17,919		76.01
76.03	03953	WOUND CARE	0	4,237		76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	216,511		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)	0	3,378,571		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,378,571		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/29/2024 5:11 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NONPATIENT PHONES)	Reconciliation	
			1.00	2.00	4.00	5.01	5A.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	194,042					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		194,042				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	731	731	13,181,795			4.00
5.01	01160	COMMUNICATIONS	448	448	99,989	274		5.01
5.02	00540	ADMITTING	827	827	557,002	11	-883,404	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	1,143	1,143	0	8	0	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	19,523	19,523	590,772	52	0	5.04
7.00	00700	OPERATION OF PLANT	71,895	71,895	405,302	12	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	1	0	8.00
9.00	00900	HOUSEKEEPING	928	928	243,199	2	0	9.00
10.00	01000	DIETARY	5,275	5,275	188	9	0	10.00
11.00	01100	CAFETERIA	0	0	744	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	958	958	1,051,245	3	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,835	3,835	179,426	5	0	14.00
15.00	01500	PHARMACY	1,632	1,632	583,414	11	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,256	6,256	141,458	25	0	16.00
17.00	01700	SOCIAL SERVICE	170	170	237,227	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,553	36,553	1,732,863	20	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,171	2,171	166,112	5	0	31.00
43.00	04300	NURSERY	0	0	274,397	1	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,355	13,355	1,279,406	34	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	311,701	2	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,855	10,855	1,129,506	21	0	54.00
56.00	05600	RADIOISOTOPE	575	575	42,894	2	0	56.00
60.00	06000	LABORATORY	4,444	4,444	1,158,365	19	0	60.00
65.00	06500	RESPIRATORY THERAPY	769	769	382,224	3	0	65.00
66.00	06600	PHYSICAL THERAPY	5,985	5,985	565,682	5	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	378,506	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	194,530	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	548	548	187,292	6	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	546	546	19,272	0	0	76.01
76.03	03953	WOUND CARE	0	0	59,755	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,620	4,620	1,209,324	17	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)	194,042	194,042	13,181,795	274	-883,404	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	1,720,808	1,657,763	3,314,746	594,188		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.868224	8.543321	0.251464	2,168.569343		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			12,728	7,897		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000966	28.821168		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: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/29/2024 5:11 pm

		Cost Center Description	ADMITTING (ACCUM. COST)	Reconciliation	CASHIERING/ACCOUNTS RECEIVABLE (ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			5.02	5A.03	5.03	5A.04	5.04	
		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
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING	34,742,685					5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	802,852	-823,266	34,802,823			5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	5,159,822	0	5,291,025	-5,416,190	30,209,899	5.04
7.00	00700	OPERATION OF PLANT	3,718,369	0	3,812,916	0	3,903,111	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	139,929	0	143,487	0	146,881	8.00
9.00	00900	HOUSEKEEPING	440,765	0	451,972	0	462,663	9.00
10.00	01000	DIETARY	299,710	0	307,331	0	314,601	10.00
11.00	01100	CAFETERIA	763,495	0	782,908	0	801,428	11.00
13.00	01300	NURSING ADMINISTRATION	1,491,371	0	1,529,292	0	1,565,467	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	516,357	0	529,486	0	542,011	14.00
15.00	01500	PHARMACY	931,198	0	954,876	0	977,464	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	734,942	0	753,629	0	771,456	16.00
17.00	01700	SOCIAL SERVICE	367,773	0	377,124	0	386,045	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,350,077	0	3,435,259	0	3,516,520	30.00
31.00	03100	INTENSIVE CARE UNIT	270,087	0	276,955	0	283,506	31.00
43.00	04300	NURSERY	612,929	0	628,514	0	643,381	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,591,593	0	3,682,916	0	3,770,035	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	698,129	0	715,880	0	732,814	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,871,144	0	1,918,722	0	1,964,109	54.00
56.00	05600	RADIOISOTOPE	131,826	0	135,178	0	138,376	56.00
60.00	06000	LABORATORY	2,554,973	0	2,619,938	0	2,681,913	60.00
65.00	06500	RESPIRATORY THERAPY	546,887	0	560,793	0	574,059	65.00
66.00	06600	PHYSICAL THERAPY	884,491	0	906,981	0	928,436	66.00
67.00	06700	OCCUPATIONAL THERAPY	505,612	0	518,468	0	530,732	67.00
68.00	06800	SPEECH PATHOLOGY	259,772	0	266,377	0	272,678	68.00
69.00	06900	ELECTROCARDIOLOGY	281,490	0	288,647	0	295,475	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	324,367	0	332,615	0	340,483	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	195,565	0	200,538	0	205,282	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	872,672	0	894,861	0	916,029	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	40,132	0	41,152	0	42,125	76.01
76.03	03953	WOUND CARE	102,302	0	104,903	0	107,384	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,282,054	0	2,340,080	0	2,395,435	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)	34,742,685	-823,266	34,802,823	-5,416,190	30,209,899	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	883,404		823,266		5,416,190	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.025427		0.023655		0.179285	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	15,254		20,484		347,364	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000439		0.000589		0.011498	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: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/29/2024 5:11 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			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
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT	99,475					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	138,804				8.00
9.00	00900	HOUSEKEEPING	928	0	98,547			9.00
10.00	01000	DIETARY	5,275	0	5,275	17,201		10.00
11.00	01100	CAFETERIA	0	0	0	0	13,246	11.00
13.00	01300	NURSING ADMINISTRATION	958	0	958	0	899	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,835	0	3,835	0	383	14.00
15.00	01500	PHARMACY	1,632	0	1,632	0	555	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,256	0	6,256	0	246	16.00
17.00	01700	SOCIAL SERVICE	170	0	170	0	249	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,553	45,699	36,553	17,201	2,072	30.00
31.00	03100	INTENSIVE CARE UNIT	2,171	461	2,171	0	152	31.00
43.00	04300	NURSERY	0	0	0	0	327	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,355	28,471	13,355	0	1,405	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	229	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,855	21,595	10,855	0	1,403	54.00
56.00	05600	RADIOISOTOPE	575	0	575	0	58	56.00
60.00	06000	LABORATORY	4,444	0	4,444	0	1,915	60.00
65.00	06500	RESPIRATORY THERAPY	769	422	769	0	432	65.00
66.00	06600	PHYSICAL THERAPY	5,985	279	5,985	0	763	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,507	0	0	470	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	213	68.00
69.00	06900	ELECTROCARDIOLOGY	548	0	548	0	268	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	546	0	546	0	23	76.01
76.03	03953	WOUND CARE	0	1,472	0	0	83	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,620	36,898	4,620	0	1,101	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)	99,475	138,804	98,547	17,201	13,246	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,602,889	173,215	588,552	646,592	945,112	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	46.271817	1.247911	5.972297	37.590373	71.350747	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,301,304	1,864	34,370	166,881	10,012	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	13.081719	0.013429	0.348768	9.701820	0.755851	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: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/29/2024 5:11 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING SALARY)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (% COSTED R EQUI)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		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
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	3,880,579					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,119,911				14.00
15.00	01500	PHARMACY	0	0	872,672			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,717	0	224,913,590		16.00
17.00	01700	SOCIAL SERVICE	0	910	0	0	2,879	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,889,003	150,337	0	11,860,424	2,456	30.00
31.00	03100	INTENSIVE CARE UNIT	111,638	21	0	340,588	49	31.00
43.00	04300	NURSERY	850,811	0	0	799,393	374	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	589,279	0	35,602,482	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	561,576	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	50,602	0	47,488,632	0	54.00
56.00	05600	RADIOISOTOPE	0	40,183	0	973,829	0	56.00
60.00	06000	LABORATORY	213	564,818	0	48,935,704	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	22,260	0	2,677,108	0	65.00
66.00	06600	PHYSICAL THERAPY	0	16,920	0	5,179,748	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,483	0	4,025,253	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,535	0	1,519,945	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,612	0	8,062,891	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	335,077	0	12,175,442	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	216,728	0	3,440,392	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	872,672	15,183,594	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	3,916	0	314,925	0	76.01
76.03	03953	WOUND CARE	52,835	19,721	0	984,205	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	976,079	98,792	0	24,787,459	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)	3,880,579	2,119,911	872,672	224,913,590	2,879	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	1,960,325	866,868	1,277,572	1,254,859	482,276	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.505163	0.408917	1.463977	0.005579	167.515109	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	50,885	125,657	63,844	203,731	10,536	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.013113	0.059275	0.073159	0.000906	3.659604	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/29/2024 5:11 pm

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		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	8,401,435		8,401,435	0	8,401,435	30.00
31.00	03100	INTENSIVE CARE UNIT	525,688		525,688	0	525,688	31.00
43.00	04300	NURSERY	1,278,971		1,278,971	0	1,278,971	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,719,035		5,719,035	0	5,719,035	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	883,669		883,669	0	883,669	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,296,039		3,296,039	0	3,296,039	54.00
56.00	05600	RADIOISOTOPE	219,228		219,228	0	219,228	56.00
60.00	06000	LABORATORY	4,035,700		4,035,700	0	4,035,700	60.00
65.00	06500	RESPIRATORY THERAPY	772,544	0	772,544	0	772,544	65.00
66.00	06600	PHYSICAL THERAPY	1,498,178	0	1,498,178	0	1,498,178	66.00
67.00	06700	OCCUPATIONAL THERAPY	687,676	0	687,676	0	687,676	67.00
68.00	06800	SPEECH PATHOLOGY	346,280	0	346,280	0	346,280	68.00
69.00	06900	ELECTROCARDIOLOGY	442,252		442,252	0	442,252	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	606,472		606,472	0	606,472	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	349,904		349,904	0	349,904	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,442,540		2,442,540	0	2,442,540	73.00
76.00	03950	OTHER ANCILLARY	0		0	0	0	76.00
76.01	03951	SLEEP LAB	83,201		83,201	0	83,201	76.01
76.03	03953	WOUND CARE	174,640		174,640	0	174,640	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,862,637		3,862,637	0	3,862,637	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,882,026		1,882,026		1,882,026	92.00
200.00		Subtotal (see instructions)	37,508,115	0	37,508,115	0	37,508,115	200.00
201.00		Less Observation Beds	1,882,026		1,882,026		1,882,026	201.00
202.00		Total (see instructions)	35,626,089	0	35,626,089	0	35,626,089	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/29/2024 5:11 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,867,212		9,867,212			30.00
31.00	03100	INTENSIVE CARE UNIT	340,588		340,588			31.00
43.00	04300	NURSERY	799,393		799,393			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,699,738	28,902,744	35,602,482	0.160636	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	560,125	1,451	561,576	1.573552	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,858,168	42,630,464	47,488,632	0.069407	0.000000	54.00
56.00	05600	RADIOISOTOPE	50,190	923,639	973,829	0.225120	0.000000	56.00
60.00	06000	LABORATORY	6,314,108	42,621,596	48,935,704	0.082469	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,273,147	403,961	2,677,108	0.288574	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,222,775	3,956,973	5,179,748	0.289238	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	840,651	3,184,602	4,025,253	0.170840	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	32,541	1,487,404	1,519,945	0.227824	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	955,898	7,106,993	8,062,891	0.054850	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,915,742	7,259,700	12,175,442	0.049811	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	304,263	3,136,129	3,440,392	0.101705	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,472,172	11,711,422	15,183,594	0.160867	0.000000	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	3,834	311,091	314,925	0.264193	0.000000	76.01
76.03	03953	WOUND CARE	8,594	975,611	984,205	0.177443	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,165,771	21,621,688	24,787,459	0.155830	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	378,293	1,614,919	1,993,212	0.944218	0.000000	92.00
200.00		Subtotal (see instructions)	47,063,203	177,850,387	224,913,590			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	47,063,203	177,850,387	224,913,590			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/29/2024 5:11 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.160636		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.573552		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.069407		54.00
56.00	05600	RADIOISOTOPE	0.225120		56.00
60.00	06000	LABORATORY	0.082469		60.00
65.00	06500	RESPIRATORY THERAPY	0.288574		65.00
66.00	06600	PHYSICAL THERAPY	0.289238		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.170840		67.00
68.00	06800	SPEECH PATHOLOGY	0.227824		68.00
69.00	06900	ELECTROCARDIOLOGY	0.054850		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.049811		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.101705		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160867		73.00
76.00	03950	OTHER ANCILLARY	0.000000		76.00
76.01	03951	SLEEP LAB	0.264193		76.01
76.03	03953	WOUND CARE	0.177443		76.03
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.155830		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.944218		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: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/29/2024 5:11 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,401,435		8,401,435	0	8,401,435	30.00
31.00	03100	INTENSIVE CARE UNIT	525,688		525,688	0	525,688	31.00
43.00	04300	NURSERY	1,278,971		1,278,971	0	1,278,971	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,719,035		5,719,035	0	5,719,035	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	883,669		883,669	0	883,669	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,296,039		3,296,039	0	3,296,039	54.00
56.00	05600	RADIOISOTOPE	219,228		219,228	0	219,228	56.00
60.00	06000	LABORATORY	4,035,700		4,035,700	0	4,035,700	60.00
65.00	06500	RESPIRATORY THERAPY	772,544	0	772,544	0	772,544	65.00
66.00	06600	PHYSICAL THERAPY	1,498,178	0	1,498,178	0	1,498,178	66.00
67.00	06700	OCCUPATIONAL THERAPY	687,676	0	687,676	0	687,676	67.00
68.00	06800	SPEECH PATHOLOGY	346,280	0	346,280	0	346,280	68.00
69.00	06900	ELECTROCARDIOLOGY	442,252		442,252	0	442,252	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	606,472		606,472	0	606,472	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	349,904		349,904	0	349,904	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,442,540		2,442,540	0	2,442,540	73.00
76.00	03950	OTHER ANCILLARY	0		0	0	0	76.00
76.01	03951	SLEEP LAB	83,201		83,201	0	83,201	76.01
76.03	03953	WOUND CARE	174,640		174,640	0	174,640	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,862,637		3,862,637	0	3,862,637	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,882,026		1,882,026		1,882,026	92.00
200.00		Subtotal (see instructions)	37,508,115	0	37,508,115	0	37,508,115	200.00
201.00		Less Observation Beds	1,882,026		1,882,026		1,882,026	201.00
202.00		Total (see instructions)	35,626,089	0	35,626,089	0	35,626,089	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/29/2024 5:11 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,867,212		9,867,212			30.00
31.00	03100	INTENSIVE CARE UNIT	340,588		340,588			31.00
43.00	04300	NURSERY	799,393		799,393			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,699,738	28,902,744	35,602,482	0.160636	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	560,125	1,451	561,576	1.573552	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,858,168	42,630,464	47,488,632	0.069407	0.000000	54.00
56.00	05600	RADIOISOTOPE	50,190	923,639	973,829	0.225120	0.000000	56.00
60.00	06000	LABORATORY	6,314,108	42,621,596	48,935,704	0.082469	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,273,147	403,961	2,677,108	0.288574	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,222,775	3,956,973	5,179,748	0.289238	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	840,651	3,184,602	4,025,253	0.170840	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	32,541	1,487,404	1,519,945	0.227824	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	955,898	7,106,993	8,062,891	0.054850	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,915,742	7,259,700	12,175,442	0.049811	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	304,263	3,136,129	3,440,392	0.101705	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,472,172	11,711,422	15,183,594	0.160867	0.000000	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	3,834	311,091	314,925	0.264193	0.000000	76.01
76.03	03953	WOUND CARE	8,594	975,611	984,205	0.177443	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,165,771	21,621,688	24,787,459	0.155830	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	378,293	1,614,919	1,993,212	0.944218	0.000000	92.00
200.00		Subtotal (see instructions)	47,063,203	177,850,387	224,913,590			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	47,063,203	177,850,387	224,913,590			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/29/2024 5:11 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
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
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03950	OTHER ANCILLARY	0.000000		76.00
76.01	03951	SLEEP LAB	0.000000		76.01
76.03	03953	WOUND CARE	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part I Date/Time Prepared: 2/29/2024 5:11 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,396,015	0	1,396,015	3,165	441.08	30.00
31.00	INTENSIVE CARE UNIT	72,878		72,878	49	1,487.31	31.00
43.00	NURSERY	21,828		21,828	374	58.36	43.00
200.00	Total (lines 30 through 199)	1,490,721		1,490,721	3,588		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	653	288,025				30.00
31.00	INTENSIVE CARE UNIT	13	19,335				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	666	307,360				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/29/2024 5:11 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	529,834	35,602,482	0.014882	869,008	12,933	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,195	561,576	0.018154	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	408,395	47,488,632	0.008600	1,303,559	11,211	54.00
56.00	05600	RADIOISOTOPE	22,870	973,829	0.023485	20,912	491	56.00
60.00	06000	LABORATORY	251,456	48,935,704	0.005138	1,421,942	7,306	60.00
65.00	06500	RESPIRATORY THERAPY	35,421	2,677,108	0.013231	539,545	7,139	65.00
66.00	06600	PHYSICAL THERAPY	203,153	5,179,748	0.039221	132,654	5,203	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,250	4,025,253	0.002795	83,048	232	67.00
68.00	06800	SPEECH PATHOLOGY	5,282	1,519,945	0.003475	4,707	16	68.00
69.00	06900	ELECTROCARDIOLOGY	28,610	8,062,891	0.003548	349,241	1,239	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	35,146	12,175,442	0.002887	621,301	1,794	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,528	3,440,392	0.005385	80,124	431	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	89,043	15,183,594	0.005864	615,960	3,612	73.00
76.00	03950	OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	17,919	314,925	0.056899	0	0	76.01
76.03	03953	WOUND CARE	4,237	984,205	0.004305	717	3	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	216,511	24,787,459	0.008735	808,023	7,058	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	312,725	1,993,212	0.156895	152,064	23,858	92.00
200.00		Total (lines 50 through 199)	2,200,575	213,906,397		7,002,805	82,526	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part III Date/Time Prepared: 2/29/2024 5:11 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	3,165	0.00	653	30.00
31.00	03100	INTENSIVE CARE UNIT		0	49	0.00	13	31.00
43.00	04300	NURSERY		0	374	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	3,588		666	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
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: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/29/2024 5:11 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.03	03953	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/29/2024 5:11 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	35,602,482	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	561,576	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	47,488,632	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	973,829	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	48,935,704	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,677,108	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,179,748	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,025,253	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,519,945	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	8,062,891	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	12,175,442	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,440,392	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,183,594	0.000000	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	314,925	0.000000	76.01
76.03	03953	WOUND CARE	0	0	0	984,205	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	24,787,459	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,993,212	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	213,906,397		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/29/2024 5:11 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	869,008	0	5,244,682	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,303,559	0	7,501,219	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	20,912	0	320,895	0	56.00
60.00	06000	LABORATORY	0.000000	1,421,942	0	2,129,165	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	539,545	0	92,595	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	132,654	0	5,503	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	83,048	0	1,336	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	4,707	0	361	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	349,241	0	1,877,952	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	621,301	0	703,169	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	80,124	0	622,560	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	615,960	0	3,763,179	0	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	15,141	0	76.01
76.03	03953	WOUND CARE	0.000000	717	0	275,385	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	808,023	0	2,777,620	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	152,064	0	277,547	0	92.00
200.00		Total (lines 50 through 199)		7,002,805	0	25,608,309	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/29/2024 5:11 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.160636	5,244,682	0	0	842,485	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.573552	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.069407	7,501,219	0	0	520,637	54.00
56.00	05600	RADIOISOTOPE	0.225120	320,895	0	0	72,240	56.00
60.00	06000	LABORATORY	0.082469	2,129,165	7,843	0	175,590	60.00
65.00	06500	RESPIRATORY THERAPY	0.288574	92,595	0	0	26,721	65.00
66.00	06600	PHYSICAL THERAPY	0.289238	5,503	0	0	1,592	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.170840	1,336	0	0	228	67.00
68.00	06800	SPEECH PATHOLOGY	0.227824	361	0	0	82	68.00
69.00	06900	ELECTROCARDIOLOGY	0.054850	1,877,952	0	0	103,006	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.049811	703,169	0	0	35,026	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.101705	622,560	0	0	63,317	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160867	3,763,179	0	17,248	605,371	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.264193	15,141	0	0	4,000	76.01
76.03	03953	WOUND CARE	0.177443	275,385	0	0	48,865	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.155830	2,777,620	0	0	432,837	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.944218	277,547	0	0	262,065	92.00
200.00		Subtotal (see instructions)		25,608,309	7,843	17,248	3,194,062	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		25,608,309	7,843	17,248	3,194,062	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/29/2024 5:11 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	647	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,775		73.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.03	03953	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	647	2,775		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	647	2,775		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/29/2024 5:11 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.160636	0	0	274,633	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.573552	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.069407	0	0	677,939	0	54.00
56.00	05600	RADIOISOTOPE	0.225120	0	0	5,943	0	56.00
60.00	06000	LABORATORY	0.082469	0	0	613,837	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.288574	0	0	2,431	0	65.00
66.00	06600	PHYSICAL THERAPY	0.289238	0	0	231,250	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.170840	0	0	391,378	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.227824	0	0	195,523	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.054850	0	0	35,957	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.049811	0	0	88,102	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.101705	0	0	44,072	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160867	0	0	74,196	0	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.264193	0	0	0	0	76.01
76.03	03953	WOUND CARE	0.177443	0	0	5,109	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.155830	0	0	556,961	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.944218	0	0	43,047	0	92.00
200.00		Subtotal (see instructions)		0	0	3,240,378	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	3,240,378	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/29/2024 5:11 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	44,116		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	47,054		54.00
56.00	05600	RADIOISOTOPE	0	1,338		56.00
60.00	06000	LABORATORY	0	50,623		60.00
65.00	06500	RESPIRATORY THERAPY	0	702		65.00
66.00	06600	PHYSICAL THERAPY	0	66,886		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	66,863		67.00
68.00	06800	SPEECH PATHOLOGY	0	44,545		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,972		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,388		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,482		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,936		73.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.03	03953	WOUND CARE	0	907		76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	86,791		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	40,646		92.00
200.00		Subtotal (see instructions)	0	473,249		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	473,249		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0075	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/29/2024 5:11 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,315	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,165	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)	2,456	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)	1,150	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	653	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)	500	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,401,435	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,401,435	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)	8,401,435	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)	2,654.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,733,375	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,733,375	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/29/2024 5:11 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	525,688	49	10,728.33	13	139,468	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)	988,336	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	2,861,179	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)	307,360	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	82,526	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	389,886	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,471,293	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)	709	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,654.48	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,882,026	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/29/2024 5:11 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,396,015	8,401,435	0.166164	1,882,026	312,725	90.00
91.00	Nursing Program cost	0	8,401,435	0.000000	1,882,026	0	91.00
92.00	Allied health cost	0	8,401,435	0.000000	1,882,026	0	92.00
93.00	All other Medical Education	0	8,401,435	0.000000	1,882,026	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/29/2024 5:11 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,906,159		30.00
31.00	03100	INTENSIVE CARE UNIT		79,945		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.160636	869,008	139,594	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.573552	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.069407	1,303,559	90,476	54.00
56.00	05600	RADIOISOTOPE	0.225120	20,912	4,708	56.00
60.00	06000	LABORATORY	0.082469	1,421,942	117,266	60.00
65.00	06500	RESPIRATORY THERAPY	0.288574	539,545	155,699	65.00
66.00	06600	PHYSICAL THERAPY	0.289238	132,654	38,369	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.170840	83,048	14,188	67.00
68.00	06800	SPEECH PATHOLOGY	0.227824	4,707	1,072	68.00
69.00	06900	ELECTROCARDIOLOGY	0.054850	349,241	19,156	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.049811	621,301	30,948	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.101705	80,124	8,149	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160867	615,960	99,088	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.264193	0	0	76.01
76.03	03953	WOUND CARE	0.177443	717	127	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.155830	808,023	125,914	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.944218	152,064	143,582	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,002,805	988,336	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)		7,002,805		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0075 | Component CCN: 15-U075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/29/2024 5:11 pm

Title XVIII | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.160636	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.573552	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.069407	10,543	732	54.00
56.00	05600	RADIOISOTOPE	0.225120	0	0	56.00
60.00	06000	LABORATORY	0.082469	69,148	5,703	60.00
65.00	06500	RESPIRATORY THERAPY	0.288574	178,734	51,578	65.00
66.00	06600	PHYSICAL THERAPY	0.289238	322,165	93,182	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.170840	268,740	45,912	67.00
68.00	06800	SPEECH PATHOLOGY	0.227824	9,989	2,276	68.00
69.00	06900	ELECTROCARDIOLOGY	0.054850	2,450	134	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.049811	175,342	8,734	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.101705	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160867	160,398	25,803	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.264193	0	0	76.01
76.03	03953	WOUND CARE	0.177443	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.155830	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.944218	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,197,509	234,054	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,197,509		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/29/2024 5:11 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		202,476		30.00
31.00	03100	INTENSIVE CARE UNIT		6,231		31.00
43.00	04300	NURSERY		45,083		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.160636	146,418	23,520	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.573552	18,602	29,271	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.069407	75,058	5,210	54.00
56.00	05600	RADIOISOTOPE	0.225120	0	0	56.00
60.00	06000	LABORATORY	0.082469	132,243	10,906	60.00
65.00	06500	RESPIRATORY THERAPY	0.288574	29,195	8,425	65.00
66.00	06600	PHYSICAL THERAPY	0.289238	4,959	1,434	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.170840	647	111	67.00
68.00	06800	SPEECH PATHOLOGY	0.227824	361	82	68.00
69.00	06900	ELECTROCARDIOLOGY	0.054850	9,194	504	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.049811	92,793	4,622	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.101705	7,369	749	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160867	83,048	13,360	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.264193	0	0	76.01
76.03	03953	WOUND CARE	0.177443	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.155830	58,176	9,066	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.944218	8,156	7,701	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		666,219	114,961	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)		666,219		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0075	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part A Date/Time Prepared: 2/29/2024 5:11 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,646,748	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	3,168	2.04
3.00	Managed Care Simulated Payments	1,981,445	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	39.88	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	1.35	30.00
31.00	Percentage of Medicaid patient days (see instructions)	26.15	31.00
32.00	Sum of lines 30 and 31	27.50	32.00
33.00	Allowable disproportionate share percentage (see instructions)	11.90	33.00
34.00	Disproportionate share adjustment (see instructions)	48,991	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E Part A Date/Time Prepared: 2/29/2024 5:11 pm

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	6,874,403,459	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000024460	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	0	168,148	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	0	168,148	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	168,148		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	1,867,055		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		1,867,055	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		124,992	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		1,402	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
55.01	Cellular therapy acquisition cost (see instructions)		0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		1,993,449	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		1,993,449	61.00
62.00	Deductibles billed to program beneficiaries		277,844	62.00
63.00	Coinsurance billed to program beneficiaries		0	63.00
64.00	Allowable bad debts (see instructions)		13,433	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		8,731	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,436	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		1,724,336	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)		0	70.75
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		0	70.93
70.94	HRR adjustment amount (see instructions)		0	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E Part A Date/Time Prepared: 2/29/2024 5:11 pm

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2022	405,938	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		2,130,274	71.00
71.01	Sequestration adjustment (see instructions)		42,605	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		1,980,362	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		107,307	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		369,787	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)		0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/29/2024 5:11 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,646,748	0		1,646,748	1,646,748	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	3,168	0		3,168	3,168	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,981,445	0	0	1,981,445	1,981,445	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1190	0.1190	0.1190	0.1190		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	48,991	0	0	48,991	48,991	11.00
11.01	Uncompensated care payments	36.00	168,148	0	0	168,148	168,148	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	1,867,055	0	0	1,867,055	1,867,055	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	1,867,055	0	0	1,867,055	1,867,055	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	124,992	0	0	124,992	124,992	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/29/2024 5:11 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	1,402	0	0	1,402	1,402	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	1,993,449	1,993,449	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	122,892	0	0	122,892	122,892	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	2,100	0	0	2,100	2,100	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	124,992	0	0	124,992	124,992	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.203636		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				405,938	405,938	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0075	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/29/2024 5:11 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,422	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,194,062	2.00
3.00	OPPS or REH payments	2,323,181	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)	3,422	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	25,091	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)	25,091	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	25,091	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	21,669	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)	3,422	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)	2,323,181	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	640	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	464,760	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,861,203	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	1,861,203	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,861,203	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)	23,380	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	15,197	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	17,116	36.00
37.00	Subtotal (see instructions)	1,876,400	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS PS&R	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,876,400	40.00
40.01	Sequestration adjustment (see instructions)	37,528	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	1,823,786	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	15,086	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	10,665	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: 15-0075	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/29/2024 5:11 pm
	Title XVIII	Hospital	PPS

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/29/2024 5:11 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,980,362		1,823,786	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)		1,980,362		1,823,786	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		107,307		15,086	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,087,669		1,838,872	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: 15-0075 | Component CCN: 15-U075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/29/2024 5:11 pm

Title XVIII | Swing Beds - SNF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		285,923		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)		285,923		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)		285,923		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0075	Period: From 10/01/2022 To 09/30/2023	Worksheet E-1 Part II Date/Time Prepared: 2/29/2024 5:11 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-0075 | Component CCN: 15-U075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-2 | Date/Time Prepared: 2/29/2024 5:11 pm

Title XVIII | Swing Beds - SNF | PPS

		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)	300,886	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	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	500	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)	300,886	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	300,886	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	300,886	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	9,129	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	291,757	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	291,757	0	19.00
19.01	Sequestration adjustment (see instructions)	5,834	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	285,923	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	0	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0075	Period: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 2/29/2024 5:11 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		473,249	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	473,249	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)	0	473,249	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	666,219	3,240,378	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)	666,219	3,240,378	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)	666,219	3,240,378	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	666,219	2,767,129	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)	0	473,249	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)	0	473,249	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)	0	473,249	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	473,249	36.00
37.00	ADJUSTMENT FOR NO SETTLEMENT	0	-473,249	37.00
38.00	Subtotal (line 36 ± line 37)	0	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)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0075	Period: From 10/01/2022 To 09/30/2023	Worksheet E-5 Date/Time Prepared: 2/29/2024 5:11 pm
	Title XVIII		PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR		
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2	0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)	0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)	0	4.00
5.00	The rate used to calculate the time value of money (see instructions)	0.00	5.00
6.00	Time value of money for operating expenses (see instructions)	0	6.00
7.00	Time value of money for capital related expenses (see instructions)	0	7.00

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

Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G | Date/Time Prepared: 2/29/2024 5:11 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-240,742	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	9,468,823	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,962,701	0	0	0	6.00
7.00	Inventory	996,052	0	0	0	7.00
8.00	Prepaid expenses	754,437	0	0	0	8.00
9.00	Other current assets	-381,206	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)	8,634,663	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,835,200	0	0	0	12.00
13.00	Land improvements	682,792	0	0	0	13.00
14.00	Accumulated depreciation	-538,267	0	0	0	14.00
15.00	Buildings	18,106,833	0	0	0	15.00
16.00	Accumulated depreciation	-11,730,194	0	0	0	16.00
17.00	Leasehold improvements	8,296,596	0	0	0	17.00
18.00	Accumulated depreciation	-5,490,127	0	0	0	18.00
19.00	Fixed equipment	2,712,300	0	0	0	19.00
20.00	Accumulated depreciation	-2,471,032	0	0	0	20.00
21.00	Automobiles and trucks	33,077	0	0	0	21.00
22.00	Accumulated depreciation	-33,077	0	0	0	22.00
23.00	Major movable equipment	11,274,176	0	0	0	23.00
24.00	Accumulated depreciation	-9,167,389	0	0	0	24.00
25.00	Minor equipment depreciable	5,477,588	0	0	0	25.00
26.00	Accumulated depreciation	-5,126,704	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)	15,861,772	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	1,805,210	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,805,210	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	26,301,645	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	910,012	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,538,614	0	0	0	38.00
39.00	Payroll taxes payable	120,164	0	0	0	39.00
40.00	Notes and loans payable (short term)	72,526	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	34,138,184	0	0	0	43.00
44.00	Other current liabilities	249,841	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	37,029,341	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	213,149	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	213,149	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	37,242,490	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-10,940,845				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)	-10,940,845	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	26,301,645	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-1 | Date/Time Prepared: 2/29/2024 5:11 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-11,136,640		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-975,555				2.00
3.00	Total (sum of line 1 and line 2)		-12,112,195		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-12,112,195		0		11.00
12.00	PLUG TO RE	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-12,112,195		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			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	PLUG TO RE		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/29/2024 5:11 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	10,666,605		10,666,605	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)	10,666,605		10,666,605	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	340,588		340,588	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)	340,588		340,588	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,007,193		11,007,193	17.00
18.00	Ancillary services	32,511,947	154,613,780	187,125,727	18.00
19.00	Outpatient services	3,585,646	23,319,802	26,905,448	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	IP CONTRACTED HOSPICE	41,546	0	41,546	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	47,146,332	177,933,582	225,079,914	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		41,683,945		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)		41,683,945		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0075	Period: From 10/01/2022 To 09/30/2023	Worksheet G-3 Date/Time Prepared: 2/29/2024 5:11 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	225,079,914	1.00
2.00	Less contractual allowances and discounts on patients' accounts	185,151,221	2.00
3.00	Net patient revenues (line 1 minus line 2)	39,928,693	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	41,683,945	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,755,252	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	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	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	779,697	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	779,697	25.00
26.00	Total (line 5 plus line 25)	-975,555	26.00
27.00	OTHER EXPENSE	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)	-975,555	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0075	Period: From 10/01/2022 To 09/30/2023	Worksheet L Parts I-III Date/Time Prepared: 2/29/2024 5:11 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	122,892	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	2,100	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	7.19	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	124,992	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00