

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: 15-2025	Period: From 09/01/2022 To 08/31/2023	Worksheet S Parts I-III Date/Time Prepared: 1/30/2024 9:16 pm
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PART I - COST REPORT STATUS

Provider use only	1. [<input checked="" type="checkbox"/>] Electronically prepared cost report 2. [<input type="checkbox"/>] Manually prepared cost report 3. [<input type="checkbox"/>] If this is an amended report enter the number of times the provider resubmitted this cost report 4. [<input type="checkbox"/>] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.	Date: 1/30/2024 Time: 9:16 pm
Contractor use only	5. [<input type="checkbox"/>] Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. [<input type="checkbox"/>] Initial Report for this Provider CCN 9. [<input type="checkbox"/>] Final Report for this Provider CCN 10. NPI Date: 11. Contractor's Vendor Code: 4 12. [<input type="checkbox"/>] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

MI SREPRESENTATION 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 CENTRAL INDIANA-AMG SPECIALTY HOSPITAL (15-2025) for the cost reporting period beginning 09/01/2022 and ending 08/31/2023 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			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

		Title XVIII		HIT	Title XIX				
		Title V							
		Part A	Part B						
1.00	HOSPITAL	0	-2,460	0	0	0 1.00			
2.00	SUBPROVIDER - IPF	0	0	0	0	0 2.00			
3.00	SUBPROVIDER - IRF	0	0	0	0	0 3.00			
5.00	SWING BED - SNF	0	0	0	0	0 5.00			
6.00	SWING BED - NF	0	0	0	0	0 6.00			
200.00	TOTAL	0	-2,460	0	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.

	1.00	2.00	3.00	4.00				
Hospital and Hospital Health Care Complex Address:								
1.00	Street: 2401 W. UNIVERSITY AVE, 8TH FLOOR N	PO Box:						
2.00	City: MUNCIE	State: IN	Zip Code: 47303	County: DELAWARE				
	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	CENTRAL INDIANA-AMG SPECIALTY HOSPITAL	152025	34620	2	02/16/2005	N	P
4.00	Subprovider - IPF							P
5.00	Subprovider - IRF							
6.00	Subprovider - (Other)							
7.00	Swing Beds - SNF							
8.00	Swing Beds - NF							
9.00	Hospital-Based SNF							
10.00	Hospital-Based NF							
11.00	Hospital-Based OLTC							
12.00	Hospital-Based HHA							
13.00	Separately Certified ASC							
14.00	Hospital-Based Hospital							
15.00	Hospital-Based Health Clinic - RHC							
16.00	Hospital-Based Health Clinic - FQHC							
17.00	Hospital-Based (CMHC) I							
17.10	Hospital-Based (CORF) I							
17.20	Hospital-Based (OPT) I							
17.30	Hospital-Based (OOT) I							
17.40	Hospital-Based (OSP) I							
18.00	Renal Dialysis							
19.00	Other							
						From:	To:	
						1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)					09/01/2022	08/31/2023	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.				N	N		
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		
22.02	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		
22.03	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	
22.04	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.							
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		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 15-2025		Period: From 09/01/2022 To 08/31/2023	Worksheet S-2 Part I Date/Time Prepared: 1/30/2024 9:16 pm				
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00			
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	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			
								Begi nning:	Endi ng:		
								1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00			
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			0				37.00			
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01			
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00			
								Y/N	Y/N		
								1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)			N		N		39.00			
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)			N		N		40.00			
								V	XVIII	XIX	
								1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital											
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)			N		N		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		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		47.00			
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.			N		N		48.00			
Teaching Hospitals											
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.			N				56.00			
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.			N				57.00			

					V	XVIII	XIX	
					1.00	2.00	3.00	
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
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.				N			59.00
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.	NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	1.00	2.00	3.00	60.00
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		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
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.	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			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
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	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings			0.00	0.00			62.01
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)			N				63.00
				1.00				
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 15-2025	Period: From 09/01/2022 To 08/31/2023	Worksheet S-2 Part I Date/Time Prepared: 1/30/2024 9:16 pm		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	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.	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	
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)	Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	65.00
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	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	
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)	Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	67.00

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				1.00
Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)				
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?			N 68.00
		1.00	2.00	3.00
Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N 70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424(d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			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.			Y 80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N 81.00
TEFRA Providers				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N 85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N 86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N 87.00
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments
			1.00	2.00
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.			0 88.00
			Wkst. A Line No.	Effective Date
			1.00	2.00
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 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 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 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 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 94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			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 96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00 97.00

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			V 1.00	XIX 2.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y 98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y 98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y 98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N 98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N 98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y 98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y 98.06
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 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N 1.00	N 109.00
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 1.00	110.00
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 1.00	111.00
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 1.00	112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.		N	0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N	116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		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.		0	118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-2025	Period: From 09/01/2022 To 08/31/2023	Worksheet S-2 Part I Date/Time Prepared: 1/30/2024 9:16 pm
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	0	0	0118.01
			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	N	N	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		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.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
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	HB0043	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: NAME: ACADIANA MANAGEMENT GROUP	Contractor's Name: NOVITAS	Contractor's Number: 07201	141.00
142.00	Street: STREET: 101 LA RUE FRANCE, SUITE 50	PO Box:		142.00
143.00	City: LAFAYETTE	State: LA	Zip Code: 70508	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.	Y		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: 15-2025	Period: From 09/01/2022 To 08/31/2023	Worksheet S-2 Part I Date/Time Prepared: 1/30/2024 9:16 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 1.00	Part B 2.00	Title V 3.00	Title XIX 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 155.00		
156.00	Subprovider - IPF	N	N	N 156.00		
157.00	Subprovider - IRF	N	N	N 157.00		
158.00	SUBPROVIDER			158.00		
159.00	SNF	N	N	N 159.00		
160.00	HOME HEALTH AGENCY	N	N	N 160.00		
161.00	CMHC	N	N	N 161.00		
161.10	CORF	N	N	N 161.10		
161.20	OUTPATIENT PHYSICAL THERAPY	N	N	N 161.20		
161.30	OUTPATIENT OCCUPATIONAL THERAPY	N	N	N 161.30		
161.40	OUTPATIENT SPEECH PATHOLOGY	N	N	N 161.40		
				1.00		
Multi campus						
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N 165.00		
	Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 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.			N 167.00		
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				N 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)					0.00 169.00
						1.00
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
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		0171.00
						2.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-2025	Period: From 09/01/2022 To 08/31/2023	Worksheet S-2 Part II Date/Time Prepared: 1/30/2024 9:16 pm																							
			Y/N 1.00	Date 2.00																							
PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions) 1.00 <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td>Y/N 1.00</td> <td>Date 2.00</td> <td>V/I 3.00</td> </tr> </table> 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. 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) 3.00 <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td>Y/N 1.00</td> <td>Type 2.00</td> <td>Date 3.00</td> </tr> </table> 4.00 Financial Data and Reports 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. 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. 5.00 <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td>Y/N 1.00</td> <td>Legal Oper. 2.00</td> </tr> </table> 6.00 Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program? 6.00 7.00 Are costs claimed for Allied Health Programs? If "Y" see instructions. 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. 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. 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. 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. 11.00 <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td>Y/N 1.00</td> </tr> </table> 12.00 Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see instructions. 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. 13.00 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions. 14.00 15.00 Bed Complement Did total beds available change from the prior cost reporting period? If yes, see instructions. 15.00 <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td colspan="2">Part A</td> <td colspan="2">Part B</td> </tr> <tr> <td></td> <td>Y/N 1.00</td> <td>Date 2.00</td> <td>Y/N 3.00</td> <td>Date 4.00</td> </tr> </table> 16.00 PS&R Data 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) 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) 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. 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. 19.00						Y/N 1.00	Date 2.00	V/I 3.00		Y/N 1.00	Type 2.00	Date 3.00		Y/N 1.00	Legal Oper. 2.00		Y/N 1.00		Part A		Part B			Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00
	Y/N 1.00	Date 2.00	V/I 3.00																								
	Y/N 1.00	Type 2.00	Date 3.00																								
	Y/N 1.00	Legal Oper. 2.00																									
	Y/N 1.00																										
	Part A		Part B																								
	Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00																							

Line	Question	Description		Y/N	Y/N	Value
		0	1.00	3.00	20.00	
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		Y/N	Date	Value
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions.			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.			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			27.00
Interest Expense		Y/N	Date	Value
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			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.			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			31.00
Purchased Services		Y/N	Date	Value
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			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.			33.00
Provider-Based Physicians		Y/N	Date	Value
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			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.			35.00

Home Office Costs		Y/N	Date	Value
36.00	Were home office costs claimed on the cost report?			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.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

Cost Report Preparer Contact Information		Y/N	Date	Value			
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.	MICHAEL		FREEMAN		41.00	
42.00	Enter the employer/company name of the cost report preparer.	TFG CONSULTING				42.00	
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	2256101100		MFREEMAN@TFCCONSULTING.ORG		43.00	

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGING DIRECTOR	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: 15-2025	Period: From 09/01/2022 To 08/31/2023	Worksheet S-3 Part I Date/Time Prepared: 1/30/2024 9:16 pm
Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips
					1.00
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	41	14,965	0.00
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				5.00
6.00	Hospital Adults & Peds. Swing Bed NF				6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		41	14,965	0.00
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)		41	14,965	0.00
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)	30.00			24.10
25.00	CMHC - CMHC				25.00
25.10	CMHC - CORF	99.10			25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	99.20			25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30			25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40			25.40
26.00	RURAL HEALTH CLINIC				26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00			26.25
27.00	Total (sum of lines 14-26)		41		27.00
28.00	Observation Bed Days				28.00
29.00	Ambulance Trips				29.00
30.00	Employee discount days (see instructions)				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	34.00

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)	5,185	79	11,123			1.00
2.00 HMO and other (see instructions)	0	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			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)	5,185	79	11,123			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)	5,185	79	11,123	0.00	94.00	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)			0			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00 RURAL HEALTH CLINIC	0	0	0	0.00		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	94.00	27.00
28.00 Observation Bed Days			0			28.00
29.00 Ambulance Trips	0		0			29.00
30.00 Employee discount days (see instruction)	0		0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0		0			33.01
34.00 Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

Component	Full Time Equivalents	Discharges			Total All Patients	
		Nonpaid Workers	Title V	Title XVIII		
		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	226	0	658 1.00
2.00 HMO and other (see instructions)				0	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	226	0	658	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
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
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 instructions)						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

	Wkst. A Line Number	Amount Reported	Classification 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	6, 951, 895	0	6, 951, 895	195, 329. 00	35. 59
2. 00	Non-physician anesthetist Part A		0	0	0	0. 00	0. 00
3. 00	Non-physician anesthetist Part B		0	0	0	0. 00	0. 00
4. 00	Physician-Part A - Administrative		0	0	0	0. 00	0. 00
4. 01	Physicians - Part A - Teaching		0	0	0	0. 00	0. 00
5. 00	Physician and Non Physician-Part B		0	0	0	0. 00	0. 00
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0. 00	0. 00
7. 00	Interns & residents (in an approved program)	21. 00	0	0	0	0. 00	0. 00
7. 01	Contracted interns and residents (in an approved programs)		0	0	0	0. 00	0. 00
8. 00	Home office and/or related organization personnel		0	0	0	0. 00	0. 00
9. 00	SNF	44. 00	0	0	0	0. 00	0. 00
10. 00	Excluded area salaries (see instructions)		0	0	0	0. 00	0. 00
OTHER WAGES & RELATED COSTS							
11. 00	Contract labor: Direct Patient Care		0	0	0	0. 00	0. 00
12. 00	Contract labor: Top level management and other management and administrative services		0	0	0	0. 00	0. 00
13. 00	Contract labor: Physician-Part A - Administrative		0	0	0	0. 00	0. 00
14. 00	Home office and/or related organization salaries and wage-related costs		0	0	0	0. 00	0. 00
14. 01	Home office salaries		0	0	0	0. 00	0. 00
14. 02	Related organization salaries		0	0	0	0. 00	0. 00
15. 00	Home office: Physician Part A - Administrative		0	0	0	0. 00	0. 00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00
16. 01	Home office Physicians Part A - Teaching		0	0	0	0. 00	0. 00
16. 02	Home office contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00
WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see instructions)		0	0	0		17. 00
18. 00	Wage-related costs (other) (see instructions)		0	0	0		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)		0	0	0		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

	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)		
25.53	Home office: Physicians Part A - Teaching - wage-related (core)	1.00	2.00	3.00	4.00	5.00	6.00	25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	1,301,177	0	1,301,177	34,353.00	37.88	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	0	0	0.00	0.00	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	114,464	0	114,464	4,170.00	27.45	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

	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)		6,951,895	0	6,951,895	195,329.00	35.59
2. 00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00
3. 00	Subtotal salaries (line 1 minus line 2)		6,951,895	0	6,951,895	195,329.00	35.59
4. 00	Subtotal other wages & related costs (see inst.)		0	0	0	0.00	0.00
5. 00	Subtotal wage-related costs (see inst.)		0	0	0	0.00	0.00
6. 00	Total (sum of lines 3 thru 5)		6,951,895	0	6,951,895	195,329.00	35.59
7. 00	Total overhead cost (see instructions)		1,415,641	0	1,415,641	38,523.00	36.75
							6.00
							7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet S-3
Part IV
Date/Time Prepared:
1/30/2024 9:16 pm

		Amount Reported	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	76,875	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	265,797	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	Workers' Compensation Insurance	129,112	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	529,060	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see 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)	1,000,844	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

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
GENERAL SERVICE COST CENTERS						
1. 00 00100	CAP REL COSTS-BLDG & FIXT		1, 219, 735	0	1, 219, 735	1. 00
2. 00 00200	CAP REL COSTS-MVBL EQUIP		0	0	0	2. 00
3. 00 00300	OTHER CAP REL COSTS		0	0	0	3. 00
4. 00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	1, 000, 844	0	1, 000, 844	4. 00
5. 00 00500	ADMINISTRATIVE & GENERAL	1, 301, 177	4, 506, 111	5, 807, 288	0	5, 807, 288
6. 00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6. 00
7. 00 00700	OPERATION OF PLANT	0	153, 028	0	153, 028	7. 00
8. 00 00800	LAUNDRY & LINEN SERVICE	0	61, 363	0	61, 363	8. 00
9. 00 00900	HOUSEKEEPING	0	221, 750	0	221, 750	9. 00
10. 00 01000	DIETARY	0	320, 631	0	320, 631	10. 00
11. 00 01100	CAFETERIA	0	0	0	0	11. 00
12. 00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12. 00
13. 00 01300	NURSING ADMINISTRATION	0	0	0	0	13. 00
14. 00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14. 00
15. 00 01500	PHARMACY	0	0	0	0	15. 00
16. 00 01600	MEDICAL RECORDS & LIBRARY	114, 464	53, 271	167, 735	0	167, 735
17. 00 01700	SOCIAL SERVICE	0	0	0	0	17. 00
18. 00 01850	RECREATIONAL THERAPY	0	0	0	0	18. 00
19. 00 01900	NONPHYSICAL ANESTHETISTS	0	0	0	0	19. 00
20. 00 02000	NURSING PROGRAM	0	0	0	0	20. 00
21. 00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21. 00
22. 00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22. 00
23. 00 02300	PARAMEDICAL PRGM- (SPECIFY)	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000	ADULTS & PEDIATRICS	4, 384, 859	1, 786, 072	6, 170, 931	0	6, 170, 931
ANCILLARY SERVICE COST CENTERS						
50. 00 05000	OPERATING ROOM	0	321, 994	321, 994	0	321, 994
54. 00 05400	RADIOLOGY-DIAGNOSTIC	170	171, 726	171, 896	0	171, 896
60. 00 06000	LABORATORY	0	236, 126	236, 126	0	236, 126
62. 30 06250	BLOOD CLOTTING FOR HEMOPHILICS	0	0	0	0	62. 30
65. 00 06500	RESPIRATORY THERAPY	993, 941	116, 988	1, 110, 929	0	1, 110, 929
66. 00 06600	PHYSICAL THERAPY	94, 817	91, 934	186, 751	0	186, 751
67. 00 06700	OCCUPATIONAL THERAPY	0	120, 146	120, 146	0	120, 146
68. 00 06800	SPEECH PATHOLOGY	0	85, 734	85, 734	0	85, 734
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	62, 467	0	62, 467	0	62, 467
73. 00 07300	DRUGS CHARGED TO PATIENTS	0	1, 523, 783	1, 523, 783	0	1, 523, 783
74. 00 07400	RENAL DIALYSIS	0	313, 116	313, 116	0	313, 116
76. 97 07697	CARDIAC REHABILITATION	0	0	0	0	76. 97
76. 98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76. 98
76. 99 07699	LITHOTRIPSY	0	0	0	0	76. 99
77. 00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
92. 00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92. 00
OTHER REIMBURSABLE COST CENTERS						
99. 10 09910	CORF	0	0	0	0	99. 10
99. 20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99. 20
99. 30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99. 30
99. 40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99. 40
102. 00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	6, 951, 895	12, 304, 352	19, 256, 247	0	19, 256, 247
NONREIMBURSABLE COST CENTERS						
200. 00	TOTAL (SUM OF LINES 118 through 199)	6, 951, 895	12, 304, 352	19, 256, 247	0	19, 256, 247
						200. 00

Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT	-3,213	1,216,522		1.00
2.00 00200	CAP REL COSTS-MVBL EQUIP	0	0		2.00
3.00 00300	OTHER CAP REL COSTS	0	0		3.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,000,844		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	-1,254,110	4,553,178		5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00 00700	OPERATION OF PLANT	0	153,028		7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	61,363		8.00
9.00 00900	HOUSEKEEPING	0	221,750		9.00
10.00 01000	DIETARY	0	320,631		10.00
11.00 01100	CAFETERIA	0	0		11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00 01300	NURSING ADMINISTRATION	0	0		13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00 01500	PHARMACY	0	0		15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	-810	166,925		16.00
17.00 01700	SOCIAL SERVICE	0	0		17.00
18.00 01850	RECREATIONAL THERAPY	0	0		18.00
19.00 01900	NONPHYSICAL ANESTHETISTS	0	0		19.00
20.00 02000	NURSING PROGRAM	0	0		20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		22.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	6,170,931		30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	321,994		50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	171,896		54.00
60.00 06000	LABORATORY	0	236,126		60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILICS	0	0		62.30
65.00 06500	RESPIRATORY THERAPY	0	1,110,929		65.00
66.00 06600	PHYSICAL THERAPY	0	186,751		66.00
67.00 06700	OCCUPATIONAL THERAPY	0	120,146		67.00
68.00 06800	SPEECH PATHOLOGY	0	85,734		68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	62,467		71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	1,523,783		73.00
74.00 07400	RENAL DIALYSIS	0	313,116		74.00
76.97 07697	CARDIAC REHABILITATION	0	0		76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99 07699	LITHOTRIPSY	0	0		76.99
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
OUTPATIENT SERVICE COST CENTERS					
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
OTHER REIMBURSABLE COST CENTERS					
99.10 09910	CORF	0	0		99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0		99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0		99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0		99.40
102.00 10200	OPiOLD TREATMENT PROGRAM	0	0		102.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-1,258,133	17,998,114		118.00
NONREIMBURSABLE COST CENTERS					
200.00	TOTAL (SUM OF LINES 118 through 199)	-1,258,133	17,998,114		200.00

	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	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	110,439	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	1,698,912	86,269	86,269	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	1,809,351	86,269	86,269	0	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	1,809,351	86,269	86,269	0	10.00
		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	110,439	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	1,785,181	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	1,895,620	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	1,895,620	0	0	0	10.00

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	480,738	687,691	14,370	25,176	11,760
2.00 CAP REL COSTS-MVBL EQUIP	0	0	0	0	0
3.00 Total (sum of lines 1-2)	480,738	687,691	14,370	25,176	11,760
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	1,219,735			1.00
2.00 CAP REL COSTS-MVBL EQUIP	0	0			2.00
3.00 Total (sum of lines 1-2)	0	1,219,735			3.00

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	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBL EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	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	477,525	687,691	1.00
2.00	CAP REL COSTS-MVBL EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	477,525	687,691	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	14,370	25,176	11,760	0	1,216,522	1.00
2.00	CAP REL COSTS-MVBL EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	14,370	25,176	11,760	0	1,216,522	3.00

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
Cost Center Description		Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
				1.00	2.00	3.00	4.00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-3,213	CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-661,194		0.00	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	-32,138			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	-810	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	NONPHYSIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
Cost Center Description		Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
				1.00	2.00	3.00	4.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY		68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0			0.00	0 32.00
33.00	ADVERTISING	A	-78,509	ADMINISTRATIVE & GENERAL		5.00	0 33.00
34.00	BAD DEBT EXPENSE	A	-466,685	ADMINISTRATIVE & GENERAL		5.00	0 34.00
35.00	MISC EXPENSE	A	-28	ADMINISTRATIVE & GENERAL		5.00	0 35.00
36.00	MEALS AND ENTERTAINMENT	A	-15,556	ADMINISTRATIVE & GENERAL		5.00	0 36.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,258,133				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: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet A-8-1
Date/Time Prepared:
1/30/2024 9:16 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
					1. 00	2. 00
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1. 00		5. 00	ADMINISTRATIVE & GENERAL	2,182,604	2,214,742	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	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,182,604	2,214,742	5. 00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
				Name	Percentage of Ownership
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6. 00	F		0. 00	ACADIANA MANAGEMENT GROUP	0. 00	6. 00
7. 00			0. 00		0. 00	7. 00
8. 00			0. 00		0. 00	8. 00
9. 00			0. 00		0. 00	9. 00
10. 00			0. 00		0. 00	10. 00
100. 00	G. Other (financial or non-financial) specify:		0. 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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-2025

Period:

From 09/01/2022

To 08/31/2023

Worksheet A-8-1

Date/Time Prepared:

1/30/2024 9:16 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	-32,138	0	1.00
2.00	0	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	-32,138		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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	MANAGEMENT COMPANY	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00	5. 00	AGGREGATE-ADMINISTRATIVE & GENERAL	691, 728	631, 728	60, 000	211, 700	300	1. 00
2. 00	0. 00		0	0	0	0	0	2. 00
3. 00	0. 00		0	0	0	0	0	3. 00
4. 00	0. 00		0	0	0	0	0	4. 00
5. 00	0. 00		0	0	0	0	0	5. 00
6. 00	0. 00		0	0	0	0	0	6. 00
7. 00	0. 00		0	0	0	0	0	7. 00
8. 00	0. 00		0	0	0	0	0	8. 00
9. 00	0. 00		0	0	0	0	0	9. 00
10. 00	0. 00		0	0	0	0	0	10. 00
200. 00			691, 728	631, 728	60, 000		300	200. 00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00	5. 00	AGGREGATE-ADMINISTRATIVE & GENERAL	30, 534	1, 527	0	0	0	1. 00
2. 00	0. 00		0	0	0	0	0	2. 00
3. 00	0. 00		0	0	0	0	0	3. 00
4. 00	0. 00		0	0	0	0	0	4. 00
5. 00	0. 00		0	0	0	0	0	5. 00
6. 00	0. 00		0	0	0	0	0	6. 00
7. 00	0. 00		0	0	0	0	0	7. 00
8. 00	0. 00		0	0	0	0	0	8. 00
9. 00	0. 00		0	0	0	0	0	9. 00
10. 00	0. 00		0	0	0	0	0	10. 00
200. 00			30, 534	1, 527	0	0	0	200. 00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00	5. 00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	30, 534	29, 466	661, 194		1. 00
2. 00	0. 00		0	0	0	0		2. 00
3. 00	0. 00		0	0	0	0		3. 00
4. 00	0. 00		0	0	0	0		4. 00
5. 00	0. 00		0	0	0	0		5. 00
6. 00	0. 00		0	0	0	0		6. 00
7. 00	0. 00		0	0	0	0		7. 00
8. 00	0. 00		0	0	0	0		8. 00
9. 00	0. 00		0	0	0	0		9. 00
10. 00	0. 00		0	0	0	0		10. 00
200. 00			0	30, 534	29, 466	661, 194		200. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-2025

Period:

From 09/01/2022

To 08/31/2023

Worksheet B

Part I

Date/Time Prepared:

1/30/2024 9:16 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1, 216, 522	1, 216, 522	0	0	1. 00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2. 00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1, 000, 844	0	0	1, 000, 844	4. 00
5.00 00500	ADMINISTRATIVE & GENERAL	4, 553, 178	126, 331	0	187, 327	4, 866, 836
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6. 00
7.00 00700	OPERATION OF PLANT	153, 028	0	0	0	153, 028
8.00 00800	LAUNDRY & LINEN SERVICE	61, 363	0	0	0	61, 363
9.00 00900	HOUSEKEEPING	221, 750	0	0	0	221, 750
10.00 01000	DIETARY	320, 631	0	0	0	320, 631
11.00 01100	CAFETERIA	0	0	0	0	0
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	0
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	0	0	0	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	166, 925	23, 251	0	16, 479	206, 655
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
18.00 01850	RECREATIONAL THERAPY	0	0	0	0	0
19.00 01900	NONPHYSICAL ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING PROGRAM	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6, 170, 931	926, 429	0	631, 275	7, 728, 635
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	321, 994	0	0	0	321, 994
54.00 05400	RADIOLOGY-DIAGNOSTIC	171, 896	0	0	24	171, 920
60.00 06000	LABORATORY	236, 126	0	0	0	236, 126
62.30 06250	BLOOD CLOTTING FOR HEMOPHILICS	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	1, 110, 929	21, 667	0	143, 095	1, 275, 691
66.00 06600	PHYSICAL THERAPY	186, 751	11, 733	0	13, 651	212, 135
67.00 06700	OCCUPATIONAL THERAPY	120, 146	11, 733	0	0	131, 879
68.00 06800	SPEECH PATHOLOGY	85, 734	11, 661	0	0	97, 395
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	62, 467	83, 717	0	8, 993	155, 177
73.00 07300	DRUGS CHARGED TO PATIENTS	1, 523, 783	0	0	0	1, 523, 783
74.00 07400	RENAL DIALYSIS	313, 116	0	0	0	313, 116
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99 07699	LI THOTRIPSY	0	0	0	0	0
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
102.00 10200	OPIOD TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	17, 998, 114	1, 216, 522	0	1, 000, 844	17, 998, 114
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	17, 998, 114	1, 216, 522	0	1, 000, 844	17, 998, 114
						202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet B
Part I
Date/Time Prepared:
1/30/2024 9:16 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	4,866,836	0				5.00
6.00	00600 MAINTENANCE & REPAIRS	0					6.00
7.00	00700 OPERATION OF PLANT	56,717	0	209,745			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	22,743	0	0	84,106		8.00
9.00	00900 HOUSEKEEPING	82,187	0	0	0	303,937	9.00
10.00	01000 DIETARY	118,835	0	0	0	0	10.00
11.00	01100 CAFETERIA	0	0	0	0	0	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300 NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500 PHARMACY	0	0	0	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	76,592	0	4,473	0	6,482	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850 RECREATIONAL THERAPY	0	0	0	0	0	18.00
19.00	01900 NONPHYSICAL ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000 NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300 PARAMED ED PRGM-(SPECI FY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,864,461	0	178,238	84,106	258,281	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	119,340	0	0	0	0	50.00
54.00	05400 RADIOLGY-DIAGNOSTIC	63,719	0	0	0	0	54.00
60.00	06000 LABORATORY	87,515	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILICS	0	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	472,808	0	4,169	0	6,041	65.00
66.00	06600 PHYSICAL THERAPY	78,623	0	2,257	0	3,271	66.00
67.00	06700 OCCUPATIONAL THERAPY	48,878	0	2,257	0	3,271	67.00
68.00	06800 SPEECH PATHOLOGY	36,097	0	2,244	0	3,251	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	57,513	0	16,107	0	23,340	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	564,758	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	116,050	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0	0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		4,866,836	0	209,745	84,106	303,937
NONREIMBURSABLE COST CENTERS							
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)	4,866,836	0	209,745	84,106	303,937	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBL EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY	439,466	0	0		10.00
11.00 01100	CAFETERIA	0	0	0		11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0		12.00
13.00 01300	NURSING ADMINISTRATION	0	0	0		13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0		14.00
15.00 01500	PHARMACY	0	0	0		15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0		16.00
17.00 01700	SOCIAL SERVICE	0	0	0		17.00
18.00 01850	RECREATIONAL THERAPY	0	0	0		18.00
19.00 01900	NONPHYSICIANS ANESTHETISTS	0	0	0		19.00
20.00 02000	NURSING PROGRAM	0	0	0		20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		22.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	439,466	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILICS	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LI THOTRI PSY	0	0	0	0	76.99
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	439,466	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
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)	439,466	0	0	0	202.00

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Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE	NONPHYSICIANS ANESTHETISTS	
				RECREATIONAL THERAPY		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBL EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY	0	294,202	0		15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0		0		16.00
17.00 01700	SOCIAL SERVICE	0	0	0		17.00
18.00 01850	RECREATIONAL THERAPY	0	0	0		18.00
19.00 01900	NONPHYSICIANS ANESTHETISTS	0	0	0		19.00
20.00 02000	NURSING PROGRAM	0	0	0		20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		22.00
23.00 02300	PARAMEDICAL PRGM-(SPECIFY)	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	294,202	0	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILICS	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	76.99
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
102.00 10200	OPIOD TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	294,202	0	0	118.00
NONREIMBURSABLE COST CENTERS						
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)	0	294,202	0	0	202.00

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		SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
		20.00	21.00	22.00	23.00
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBL EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
6.00 00600	MAINTENANCE & REPAIRS				6.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
12.00 01200	MAINTENANCE OF PERSONNEL				12.00
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
18.00 01850	RECREATIONAL THERAPY				18.00
19.00 01900	NONPHYSICAL ANESTHETISTS				19.00
20.00 02000	NURSING PROGRAM	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)			0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	0	0	11,847,389
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	0	0	441,334
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	235,639
60.00 06000	LABORATORY	0	0	0	323,641
62.30 06250	BLOOD CLOTTING FOR HEMOPHILICS	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	0	0	0	1,758,709
66.00 06600	PHYSICAL THERAPY	0	0	0	296,286
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	186,285
68.00 06800	SPEECH PATHOLOGY	0	0	0	138,987
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	252,137
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,088,541
74.00 07400	RENAL DIALYSIS	0	0	0	429,166
76.97 07697	CARDIAC REHABILITATION	0	0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0
76.99 07699	LITHOTRIPSY	0	0	0	0
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
OTHER REIMBURSABLE COST CENTERS					
99.10 09910	CORF	0	0	0	0
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0
102.00 10200	OPIOD TREATMENT PROGRAM	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	17,998,114
NONREIMBURSABLE COST CENTERS					
200.00	Cross Foot Adjustments	0	0	0	0
201.00	Negative Cost Centers	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	0	0	0	17,998,114
					202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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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-MVBL EQUIP			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00 00500	ADMINISTRATIVE & GENERAL			5.00
6.00 00600	MAINTENANCE & REPAIRS			6.00
7.00 00700	OPERATION OF PLANT			7.00
8.00 00800	LAUNDRY & LINEN SERVICE			8.00
9.00 00900	HOUSEKEEPING			9.00
10.00 01000	DIETARY			10.00
11.00 01100	CAFETERIA			11.00
12.00 01200	MAINTENANCE OF PERSONNEL			12.00
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
18.00 01850	RECREATIONAL THERAPY			18.00
19.00 01900	NONPHYSICAL ANESTHETISTS			19.00
20.00 02000	NURSING PROGRAM			20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00 02300	PARAMEDICAL PRGM-(SPECIFY)			23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000	ADULTS & PEDIATRICS	0	11,847,389	30.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000	OPERATING ROOM	0	441,334	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	235,639	54.00
60.00 06000	LABORATORY	0	323,641	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILICS	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	0	1,758,709	65.00
66.00 06600	PHYSICAL THERAPY	0	296,286	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	186,285	67.00
68.00 06800	SPEECH PATHOLOGY	0	138,987	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	252,137	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	2,088,541	73.00
74.00 07400	RENAL DIALYSIS	0	429,166	74.00
76.97 07697	CARDIAC REHABILITATION	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	76.99
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
OUTPATIENT SERVICE COST CENTERS				
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10 09910	CORF	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
102.00 10200	OPIOD TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	17,998,114	118.00
NONREIMBURSABLE COST CENTERS				
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	17,998,114	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	126,331	0	126,331	0
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	0	0	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	0	0	0	9.00
10.00 01000	DIETARY	0	0	0	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	23,251	0	23,251	0
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
18.00 01850	RECREATIONAL THERAPY	0	0	0	0	18.00
19.00 01900	NONPHYSICAL ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING PROGRAM	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	926,429	0	926,429	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILICS	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	0	21,667	0	21,667	0
66.00 06600	PHYSICAL THERAPY	0	11,733	0	11,733	0
67.00 06700	OCCUPATIONAL THERAPY	0	11,733	0	11,733	0
68.00 06800	SPEECH PATHOLOGY	0	11,661	0	11,661	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	83,717	0	83,717	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LI THOTRI PSY	0	0	0	0	76.99
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
102.00 10200	OPIOD TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	1,216,522	0	1,216,522	0
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	1,216,522	0	1,216,522	0

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	126,331	0	0	0	0	5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0	1,472	0	0	6.00
7.00	00700 OPERATION OF PLANT	1,472	0	0	1,472	0	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	590	0	0	590	0	8.00
9.00	00900 HOUSEKEEPING	2,133	0	0	0	2,133	9.00
10.00	01000 DIETARY	3,085	0	0	0	0	10.00
11.00	01100 CAFETERIA	0	0	0	0	0	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300 NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500 PHARMACY	0	0	0	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1,988	0	31	0	0	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850 RECREATIONAL THERAPY	0	0	0	0	0	18.00
19.00	01900 NONPHYSICIANS-ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000 NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300 PARAMEDIC PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	74,354	0	1,251	590	1,813	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,098	0	0	0	0	50.00
54.00	05400 RADIOLGY-DIAGNOSTIC	1,654	0	0	0	0	54.00
60.00	06000 LABORATORY	2,272	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILICS	0	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	12,273	0	29	0	0	65.00
66.00	06600 PHYSICAL THERAPY	2,041	0	16	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,269	0	16	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	937	0	16	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,493	0	113	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	14,660	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	3,012	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0	0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	126,331	0	1,472	590	2,133	118.00
NONREIMBURSABLE COST CENTERS							
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)	126,331	0	1,472	590	2,133	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-2025

Period:

From 09/01/2022

To 08/31/2023

Worksheet B

Part II

Date/Time Prepared:

1/30/2024 9:16 pm

Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBL EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY	3,085				10.00
11.00 01100	CAFETERIA	0	0			11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0		12.00
13.00 01300	NURSING ADMINISTRATION	0	0	0		13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0		14.00
15.00 01500	PHARMACY	0	0	0		15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0		16.00
17.00 01700	SOCIAL SERVICE	0	0	0		17.00
18.00 01850	RECREATIONAL THERAPY	0	0	0		18.00
19.00 01900	NONPHYSICIANS ANESTHETISTS	0	0	0		19.00
20.00 02000	NURSING PROGRAM	0	0	0		20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		22.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	3,085	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILICS	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LI THOTRI PSY	0	0	0	0	76.99
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	3,085	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
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)	3,085	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-2025

Period:

From 09/01/2022

To 08/31/2023

Worksheet B

Part II

Date/Time Prepared:

1/30/2024 9:16 pm

Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE	NONPHYSICAL ANESTHETISTS	
				RECREATIONAL THERAPY		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBL EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY	0	25,315	0		15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0				16.00
17.00 01700	SOCIAL SERVICE	0	0	0		17.00
18.00 01850	RECREATIONAL THERAPY	0	0	0		18.00
19.00 01900	NONPHYSICAL ANESTHETISTS	0	0	0		19.00
20.00 02000	NURSING PROGRAM	0	0	0		20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		22.00
23.00 02300	PARAMEDICAL PRGM-(SPECIFY)	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	25,315	0	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILICS	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	76.99
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
102.00 10200	OPIOD TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	25,315	0	0	0
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	0	25,315	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-2025

Period:

From 09/01/2022

To 08/31/2023

Worksheet B

Part II

Date/Time Prepared:

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Cost Center Description	NURSING PROGRAM	INTERNS & RESIDENTS		PARAMEDIC PROGRAM	Subtotal
		SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
		20.00	21.00	22.00	23.00
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBL EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
6.00 00600	MAINTENANCE & REPAIRS				6.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
12.00 01200	MAINTENANCE OF PERSONNEL				12.00
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
18.00 01850	RECREATIONAL THERAPY				18.00
19.00 01900	NONPHYSICAL ANESTHETISTS				19.00
20.00 02000	NURSING PROGRAM	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00 02300	PARAMEDIC PRGM-(SPECIFY)			0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS				1,032,837
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM				50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC				54.00
60.00 06000	LABORATORY				60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILICS				62.30
65.00 06500	RESPIRATORY THERAPY				65.00
66.00 06600	PHYSICAL THERAPY				66.00
67.00 06700	OCCUPATIONAL THERAPY				67.00
68.00 06800	SPEECH PATHOLOGY				68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT				71.00
73.00 07300	DRUGS CHARGED TO PATIENTS				73.00
74.00 07400	RENAL DIALYSIS				74.00
76.97 07697	CARDIAC REHABILITATION				76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99 07699	LITHOTRIPSY				76.99
77.00 07700	ALLOGENEIC HSCT ACQUISITION				77.00
OUTPATIENT SERVICE COST CENTERS					
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
OTHER REIMBURSABLE COST CENTERS					
99.10 09910	CORF				99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY				99.40
102.00 10200	OPQRST TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	1,216,522
NONREIMBURSABLE COST CENTERS					
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	0	0	1,216,522
					202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet B
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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-MVBL EQUIP			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00 00500	ADMINISTRATIVE & GENERAL			5.00
6.00 00600	MAINTENANCE & REPAIRS			6.00
7.00 00700	OPERATION OF PLANT			7.00
8.00 00800	LAUNDRY & LINEN SERVICE			8.00
9.00 00900	HOUSEKEEPING			9.00
10.00 01000	DIETARY			10.00
11.00 01100	CAFETERIA			11.00
12.00 01200	MAINTENANCE OF PERSONNEL			12.00
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
18.00 01850	RECREATIONAL THERAPY			18.00
19.00 01900	NONPHYSICAL AND ANESTHETISTS			19.00
20.00 02000	NURSING PROGRAM			20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00 02300	PARAMEDICAL PRGM-(SPECIFY)			23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000	ADULTS & PEDIATRICS	0	1,032,837	30.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000	OPERATING ROOM	0	3,098	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	1,654	54.00
60.00 06000	LABORATORY	0	2,272	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILICS	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	0	34,011	65.00
66.00 06600	PHYSICAL THERAPY	0	13,813	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	13,041	67.00
68.00 06800	SPEECH PATHOLOGY	0	12,637	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	85,487	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	14,660	73.00
74.00 07400	RENAL DIALYSIS	0	3,012	74.00
76.97 07697	CARDIAC REHABILITATION	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	76.99
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
OUTPATIENT SERVICE COST CENTERS				
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10 09910	CORF	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
102.00 10200	OPIOD TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	1,216,522	118.00
NONREIMBURSABLE COST CENTERS				
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	1,216,522	202.00

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00		4.00	5A	5.00
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT	16,900					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		16,900				2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	6,951,895			4.00
5.00 00500 ADMINISTRATIVE & GENERAL	1,755	1,755	1,301,177	-4,866,836	13,131,278	5.00
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700 OPERATION OF PLANT	0	0	0	0	153,028	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	0	0	61,363	8.00
9.00 00900 HOUSEKEEPING	0	0	0	0	221,750	9.00
10.00 01000 DIETARY	0	0	0	0	320,631	10.00
11.00 01100 CAFETERIA	0	0	0	0	0	11.00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300 NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 01500 PHARMACY	0	0	0	0	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	323	323	114,464	0	206,655	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
18.00 01850 RECREATIONAL THERAPY	0	0	0	0	0	18.00
19.00 01900 NONPHYSICAL ANESTHETISTS	0	0	0	0	0	19.00
20.00 02000 NURSING PROGRAM	0	0	0	0	0	20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00 02300 PARAMEDIC PRGM-(SPECI FY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	12,870	12,870	4,384,859	0	7,728,635	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	321,994	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	170	0	171,920	54.00
60.00 06000 LABORATORY	0	0	0	0	236,126	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILICS	0	0	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	301	301	993,941	0	1,275,691	65.00
66.00 06600 PHYSICAL THERAPY	163	163	94,817	0	212,135	66.00
67.00 06700 OCCUPATIONAL THERAPY	163	163	0	0	131,879	67.00
68.00 06800 SPEECH PATHOLOGY	162	162	0	0	97,395	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,163	1,163	62,467	0	155,177	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	1,523,783	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	313,116	74.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699 LITHOTRIPSY	0	0	0	0	0	76.99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910 CORF	0	0	0	0	0	99.10
99.20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	16,900	16,900	6,951,895	-4,866,836	13,131,278	118.00
NONREIMBURSABLE COST CENTERS						
200.00 200 Cross Foot Adjustments						200.00
201.00 201 Negative Cost Centers						201.00
202.00 202 Cost to be allocated (per Wkst. B, Part I)	1,216,522	0	1,000,844		4,866,836	202.00
203.00 203 Unit cost multiplier (Wkst. B, Part I)	71.983550	0.000000	0.143967		0.370629	203.00
204.00 204 Cost to be allocated (per Wkst. B, Part II)			0		126,331	204.00
205.00 205 Unit cost multiplier (Wkst. B, Part III)			0.000000		0.009621	205.00
206.00 206 NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00 207 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-2025

Worksheet B-1

Period: From 09/01/2022 To 08/31/2023

Date/Time Prepared: 1/30/2024 9:16 pm

Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
GENERAL SERVICE COST CENTERS						
1. 00 00100	CAP REL COSTS-BLDG & FIXT					1. 00
2. 00 00200	CAP REL COSTS-MVBL EQUIP					2. 00
4. 00 00400	EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00 00500	ADMINISTRATIVE & GENERAL					5. 00
6. 00 00600	MAINTENANCE & REPAIRS	15, 145				6. 00
7. 00 00700	OPERATION OF PLANT	0	15, 145			7. 00
8. 00 00800	LAUNDRY & LINEN SERVICE	0	0	11, 123		8. 00
9. 00 00900	HOUSEKEEPING	0	0	0	15, 145	9. 00
10. 00 01000	DIETARY	0	0	0	0	33, 369
11. 00 01100	CAFETERIA	0	0	0	0	11. 00
12. 00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12. 00
13. 00 01300	NURSING ADMINISTRATION	0	0	0	0	13. 00
14. 00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14. 00
15. 00 01500	PHARMACY	0	0	0	0	15. 00
16. 00 01600	MEDICAL RECORDS & LIBRARY	323	323	0	323	0
17. 00 01700	SOCIAL SERVICE	0	0	0	0	17. 00
18. 00 01850	RECREATIONAL THERAPY	0	0	0	0	18. 00
19. 00 01900	NONPHYSICAL ANESTHETISTS	0	0	0	0	19. 00
20. 00 02000	NURSING PROGRAM	0	0	0	0	20. 00
21. 00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21. 00
22. 00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22. 00
23. 00 02300	PARAMEDIC PRGM-(SPECIFY)	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000	ADULTS & PEDIATRICS	12, 870	12, 870	11, 123	12, 870	33, 369
ANCILLARY SERVICE COST CENTERS						
50. 00 05000	OPERATING ROOM	0	0	0	0	50. 00
54. 00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54. 00
60. 00 06000	LABORATORY	0	0	0	0	60. 00
62. 30 06250	BLOOD CLOTTING FOR HEMOPHILICS	0	0	0	0	62. 30
65. 00 06500	RESPIRATORY THERAPY	301	301	0	301	0
66. 00 06600	PHYSICAL THERAPY	163	163	0	163	0
67. 00 06700	OCCUPATIONAL THERAPY	163	163	0	163	0
68. 00 06800	SPEECH PATHOLOGY	162	162	0	162	0
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1, 163	1, 163	0	1, 163	0
73. 00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73. 00
74. 00 07400	RENAL DIALYSIS	0	0	0	0	74. 00
76. 97 07697	CARDIAC REHABILITATION	0	0	0	0	76. 97
76. 98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76. 98
76. 99 07699	LI THOTRI PSY	0	0	0	0	76. 99
77. 00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
92. 00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92. 00
OTHER REIMBURSABLE COST CENTERS						
99. 10 09910	CORF	0	0	0	0	99. 10
99. 20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99. 20
99. 30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99. 30
99. 40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99. 40
102. 00 10200	OPOLID TREATMENT PROGRAM	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	15, 145	15, 145	11, 123	15, 145	33, 369
NONREIMBURSABLE COST CENTERS						
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)	0	209, 745	84, 106	303, 937	439, 466
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	13, 849125	7, 561449	20, 068471	13, 169888
204. 00	Cost to be allocated (per Wkst. B, Part II)	0	1, 472	590	2, 133	3, 085
205. 00	Unit cost multiplier (Wkst. B, Part III)	0. 000000	0. 097194	0. 053043	0. 140839	0. 092451
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: 15-2025

Worksheet B-1

Period:
From 09/01/2022
To 08/31/2023Date/Time Prepared:
1/30/2024 9:16 pm

Cost Center Description		CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBL EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA	0					11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300 NURSING ADMINISTRATION	0	0	0			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500 PHARMACY	0	0	0	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850 RECREATIONAL THERAPY	0	0	0	0	0	18.00
19.00	01900 NONPHYSICIANS ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000 NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300 PARAMEDICAL PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	0	0	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400 RADIOLGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILICS	0	0	0	0	0	62.30
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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0	0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
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)	0	0	0	0	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	0.000000	0.000000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	0	0	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part III)	0.000000	0.000000	0.000000	0.000000	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE	NONPHYSICAL ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	
			RECREATIONAL THERAPY (TIME SPENT)			
			16.00	17.00	18.00	19.00
					20.00	
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 CAP REL COSTS-MVBL EQUIP					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMINISTRATIVE & GENERAL					5.00
6.00	00600 MAINTENANCE & REPAIRS					6.00
7.00	00700 OPERATION OF PLANT					7.00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPING					9.00
10.00	01000 DIETARY					10.00
11.00	01100 CAFETERIA					11.00
12.00	01200 MAINTENANCE OF PERSONNEL					12.00
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	4,170	0			16.00
17.00	01700 SOCIAL SERVICE	0	0	0		17.00
18.00	01850 RECREATIONAL THERAPY	0	0	0		18.00
19.00	01900 NONPHYSICAL ANESTHETISTS	0	0	0	0	19.00
20.00	02000 NURSING PROGRAM	0	0	0		20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		22.00
23.00	02300 PARAMED PRGM-(SPECIFY)	0	0	0		23.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	4,170	0	0	0	30.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	0	50.00
54.00	05400 RADIOLGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILICS	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0	0	76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					92.00
	OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF	0	0	0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	4,170	0	0	0	118.00
	NONREIMBURSABLE COST CENTERS					
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)	294,202	0	0	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	70.552038	0.000000	0.000000	0.000000	0.000000
204.00	Cost to be allocated (per Wkst. B, Part II)	25,315	0	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part III)	6.070743	0.000000	0.000000	0.000000	0.000000
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)				0.000000	207.00

Cost Center Description	INTERNS & RESIDENTS			PARAMED PRGM (ASSIGNED TIME)	23.00
	SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)			
	21.00	22.00			
GENERAL SERVICE COST CENTERS					
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 CAP REL COSTS-MVBL EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500 ADMINISTRATIVE & GENERAL					5.00
6.00 00600 MAINTENANCE & REPAIRS					6.00
7.00 00700 OPERATION OF PLANT					7.00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
9.00 00900 HOUSEKEEPING					9.00
10.00 01000 DIETARY					10.00
11.00 01100 CAFETERIA					11.00
12.00 01200 MAINTENANCE OF PERSONNEL					12.00
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
18.00 01850 RECREATIONAL THERAPY					18.00
19.00 01900 NONPHYSICAL ANESTHETISTS					19.00
20.00 02000 NURSING PROGRAM					20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0		0		21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV					22.00
23.00 02300 PARAMED PRGM-(SPECIFY)			0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS	0	0	0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	0	0		50.00
54.00 05400 RADIOLGY-DIAGNOSTIC	0	0	0		54.00
60.00 06000 LABORATORY	0	0	0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILICS	0	0	0		62.30
65.00 06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00 07400 RENAL DIALYSIS	0	0	0		74.00
76.97 07697 CARDIAC REHABILITATION	0	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99 07699 LI THOTRIPSY	0	0	0		76.99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0		77.00
OUTPATIENT SERVICE COST CENTERS					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS					
99.10 09910 CORF	0	0	0		99.10
99.20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0		102.00
SPECIAL PURPOSE COST CENTERS					
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0		118.00
NONREIMBURSABLE COST CENTERS					
200.00 200.00 Cross Foot Adjustments					200.00
201.00 201.00 Negative Cost Centers					201.00
202.00 202.00 Cost to be allocated (per Wkst. B, Part I)	0	0	0		202.00
203.00 203.00 Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	0.000000		203.00
204.00 204.00 Cost to be allocated (per Wkst. B, Part II)	0	0	0		204.00
205.00 205.00 Unit cost multiplier (Wkst. B, Part III)	0.000000	0.000000	0.000000		205.00
206.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)			0		206.00
207.00 207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet C
Part I
Date/Time Prepared:
1/30/2024 9:16 pm

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital Costs	PPS		
			Total Costs	RCE Di sal l owance				
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00 03000	ADULTS & PEDIATRICS	11,847,389			11,847,389	0	11,847,389	30.00
ANCILLARY SERVICE COST CENTERS								
50.00 05000	OPERATING ROOM	441,334			441,334	0	441,334	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	235,639			235,639	0	235,639	54.00
60.00 06000	LABORATORY	323,641			323,641	0	323,641	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILICS	0			0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	1,758,709	0	1,758,709	0	1,758,709	65.00	
66.00 06600	PHYSICAL THERAPY	296,286	0	296,286	0	296,286	66.00	
67.00 06700	OCCUPATIONAL THERAPY	186,285	0	186,285	0	186,285	67.00	
68.00 06800	SPEECH PATHOLOGY	138,987	0	138,987	0	138,987	68.00	
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	252,137			252,137	0	252,137	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,088,541			2,088,541	0	2,088,541	73.00
74.00 07400	RENAL DIALYSIS	429,166			429,166	0	429,166	74.00
76.97 07697	CARDIAC REHABILITATION	0			0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0			0	0	0	76.98
76.99 07699	LITHOTRIPSY	0			0	0	0	76.99
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0			0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10 09910	CORF	0			0	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0			0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0			0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0			0	0	0	99.40
102.00 10200	OPIOID TREATMENT PROGRAM	0			0	0	0	102.00
200.00	Subtotal (see instructions)	17,998,114	0	17,998,114	0	17,998,114	200.00	
201.00	Less Observation Beds	0			0	0	0	201.00
202.00	Total (see instructions)	17,998,114	0	17,998,114	0	17,998,114	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet C
Part I
Date/Time Prepared:
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			Title XVIII		Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	19, 883, 010		19, 883, 010			30. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	2, 369, 454	0	2, 369, 454	0. 186260	0. 000000	50. 00
54. 00	05400 RADIOLogy-DIAGNOSTIC	1, 638, 421	0	1, 638, 421	0. 143821	0. 000000	54. 00
60. 00	06000 LABORATORY	1, 518, 129	0	1, 518, 129	0. 213184	0. 000000	60. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILICS	0	0	0	0. 000000	0. 000000	62. 30
65. 00	06500 RESPIRATORY THERAPY	13, 542, 211	0	13, 542, 211	0. 129869	0. 000000	65. 00
66. 00	06600 PHYSICAL THERAPY	385, 780	0	385, 780	0. 768018	0. 000000	66. 00
67. 00	06700 OCCUPATIONAL THERAPY	253, 995	0	253, 995	0. 733420	0. 000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	692, 731	0	692, 731	0. 200636	0. 000000	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 934, 979	0	1, 934, 979	0. 130305	0. 000000	71. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 144, 471	0	2, 144, 471	0. 973919	0. 000000	73. 00
74. 00	07400 RENAL DIALYSIS	663, 577	0	663, 577	0. 646746	0. 000000	74. 00
76. 97	07697 CARDIAC REHABILITATION	0	0	0	0. 000000	0. 000000	76. 97
76. 98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0. 000000	0. 000000	76. 98
76. 99	07699 LITHOTRIPSY	0	0	0	0. 000000	0. 000000	76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0. 000000	0. 000000	77. 00
	OUTPATIENT SERVICE COST CENTERS						
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0. 000000	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0	0	0			99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0			99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0			99. 40
102. 00	10200 OUTPATIENT TREATMENT PROGRAM	0	0	0			102. 00
200. 00	Subtotal (see instructions)	45, 026, 758	0	45, 026, 758			200. 00
201. 00	Less Observation Beds						201. 00
202. 00	Total (see instructions)	45, 026, 758	0	45, 026, 758			202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-2025

Period:

From 09/01/2022

To 08/31/2023

Worksheet C

Part I

Date/Time Prepared:

1/30/2024 9:16 pm

Title XVIII

Hospital

PPS

Cost Center Description	PPS Inpatient Ratio	Title XVIII		
		Hospital	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 ADULTS & PEDIATRICS	11.00			30.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0.186260			50.00
54.00 05400 RADIOLGY-DIAGNOSTIC	0.143821			54.00
60.00 06000 LABORATORY	0.213184			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILICS	0.000000			62.30
65.00 06500 RESPIRATORY THERAPY	0.129869			65.00
66.00 06600 PHYSICAL THERAPY	0.768018			66.00
67.00 06700 OCCUPATIONAL THERAPY	0.733420			67.00
68.00 06800 SPEECH PATHOLOGY	0.200636			68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.130305			71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.973919			73.00
74.00 07400 RENAL DIALYSIS	0.646746			74.00
76.97 07697 CARDIAC REHABILITATION	0.000000			76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99 07699 LITHOTRIPSY	0.000000			76.99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.000000			77.00
OUTPATIENT SERVICE COST CENTERS				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS				
99.10 09910 CORF				99.10
99.20 09920 OUTPATIENT PHYSICAL THERAPY				99.20
99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40 09940 OUTPATIENT SPEECH PATHOLOGY				99.40
102.00 10200 OPIOID TREATMENT PROGRAM				102.00
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: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet C
Part I
Date/Time Prepared:
1/30/2024 9:16 pm

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital Costs	PPS		
			Total Costs	RCE Di sal l owance				
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00 03000	ADULTS & PEDIATRICS	11,847,389			11,847,389	0	11,847,389	30.00
ANCILLARY SERVICE COST CENTERS								
50.00 05000	OPERATING ROOM	441,334			441,334	0	441,334	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	235,639			235,639	0	235,639	54.00
60.00 06000	LABORATORY	323,641			323,641	0	323,641	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILICS	0			0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	1,758,709	0	1,758,709	0	1,758,709	65.00	
66.00 06600	PHYSICAL THERAPY	296,286	0	296,286	0	296,286	66.00	
67.00 06700	OCCUPATIONAL THERAPY	186,285	0	186,285	0	186,285	67.00	
68.00 06800	SPEECH PATHOLOGY	138,987	0	138,987	0	138,987	68.00	
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	252,137			252,137	0	252,137	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,088,541			2,088,541	0	2,088,541	73.00
74.00 07400	RENAL DIALYSIS	429,166			429,166	0	429,166	74.00
76.97 07697	CARDIAC REHABILITATION	0			0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0			0	0	0	76.98
76.99 07699	LITHOTRIPSY	0			0	0	0	76.99
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0			0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10 09910	CORF	0			0	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0			0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0			0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0			0	0	0	99.40
102.00 10200	OPIOID TREATMENT PROGRAM	0			0	0	0	102.00
200.00	Subtotal (see instructions)	17,998,114	0	17,998,114	0	17,998,114	200.00	
201.00	Less Observation Beds	0			0	0	0	201.00
202.00	Total (see instructions)	17,998,114	0	17,998,114	0	17,998,114	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet C
Part I
Date/Time Prepared:
1/30/2024 9:16 pm

Cost Center Description	Title XIX			Hospital	PPS
	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
	Inpatient	Outpatient	Total (col. 6 + col. 7)		
	6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS	19,883,010		19,883,010		30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	2,369,454	0	2,369,454	0.186260	0.000000
54.00 05400 RADIOLGY-DIAGNOSTIC	1,638,421	0	1,638,421	0.143821	0.000000
60.00 06000 LABORATORY	1,518,129	0	1,518,129	0.213184	0.000000
62.30 06250 BLOOD CLOTTING FOR HEMOPHILICS	0	0	0	0.000000	0.000000
65.00 06500 RESPIRATORY THERAPY	13,542,211	0	13,542,211	0.129869	0.000000
66.00 06600 PHYSICAL THERAPY	385,780	0	385,780	0.768018	0.000000
67.00 06700 OCCUPATIONAL THERAPY	253,995	0	253,995	0.733420	0.000000
68.00 06800 SPEECH PATHOLOGY	692,731	0	692,731	0.200636	0.000000
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,934,979	0	1,934,979	0.130305	0.000000
73.00 07300 DRUGS CHARGED TO PATIENTS	2,144,471	0	2,144,471	0.973919	0.000000
74.00 07400 RENAL DIALYSIS	663,577	0	663,577	0.646746	0.000000
76.97 07697 CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000
76.99 07699 LI THOTRI PSY	0	0	0	0.000000	0.000000
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000
OTHER REIMBURSABLE COST CENTERS					
99.10 09910 CORF	0	0	0		99.10
99.20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
102.00 10200 OPOLID TREATMENT PROGRAM	0	0	0		102.00
200.00 Subtotal (see instructions)	45,026,758	0	45,026,758		200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)	45,026,758	0	45,026,758		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet C
Part I
Date/Time Prepared:
1/30/2024 9:16 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
		11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS				30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.186260			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.143821			54.00
60.00	06000 LABORATORY	0.213184			60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILICS	0.000000			62.30
65.00	06500 RESPIRATORY THERAPY	0.129869			65.00
66.00	06600 PHYSICAL THERAPY	0.768018			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.733420			67.00
68.00	06800 SPEECH PATHOLOGY	0.200636			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.130305			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.973919			73.00
74.00	07400 RENAL DIALYSIS	0.646746			74.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699 LITHOTRIPSY	0.000000			76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000			77.00
	OUTPATIENT SERVICE COST CENTERS				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
	OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF				99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY				99.40
102.00	10200 OPIOID TREATMENT PROGRAM				102.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

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

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet C
Part II
Date/Time Prepared:
1/30/2024 9:16 pm

Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Title XIX		Hospital	Operating Cost Reduction Amount	PPS
		Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	441,334	3,098	438,236	0	0 50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	235,639	1,654	233,985	0	0 54.00
60.00 06000	LABORATORY	323,641	2,272	321,369	0	0 60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00 06500	RESPIRATORY THERAPY	1,758,709	34,011	1,724,698	0	0 65.00
66.00 06600	PHYSICAL THERAPY	296,286	13,813	282,473	0	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	186,285	13,041	173,244	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	138,987	12,637	126,350	0	0 68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	252,137	85,487	166,650	0	0 71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,088,541	14,660	2,073,881	0	0 73.00
74.00 07400	RENAL DIALYSIS	429,166	3,012	426,154	0	0 74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99 07699	LI THOTRI PSY	0	0	0	0	0 76.99
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0 77.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0 99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0 99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0 99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0 99.40
102.00 10200	OPIOD TREATMENT PROGRAM	0	0	0	0	0 102.00
200.00	Subtotal (sum of lines 50 thru 199)	6,150,725	183,685	5,967,040	0	0 200.00
201.00	Less Observation Beds	0	0	0	0	0 201.00
202.00	Total (line 200 minus line 201)	6,150,725	183,685	5,967,040	0	0 202.00

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

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet C
Part II
Date/Time Prepared:
1/30/2024 9:16 pm

Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Title XIX		Hospital	PPS
			Outpatient Cost to Charge Ratio (col. 6 / col. 7)	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	441,334	2,369,454	0.186260		50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	235,639	1,638,421	0.143821		54.00
60.00 06000	LABORATORY	323,641	1,518,129	0.213184		60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000		62.30
65.00 06500	RESPIRATORY THERAPY	1,758,709	13,542,211	0.129869		65.00
66.00 06600	PHYSICAL THERAPY	296,286	385,780	0.768018		66.00
67.00 06700	OCCUPATIONAL THERAPY	186,285	253,995	0.733420		67.00
68.00 06800	SPEECH PATHOLOGY	138,987	692,731	0.200636		68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	252,137	1,934,979	0.130305		71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,088,541	2,144,471	0.973919		73.00
74.00 07400	RENAL DIALYSIS	429,166	663,577	0.646746		74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0.000000		76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000		76.98
76.99 07699	LI THOTRI PSY	0	0	0.000000		76.99
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000		77.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0.000000		99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0.000000		99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0.000000		99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0.000000		99.40
102.00 10200	OPIOD TREATMENT PROGRAM	0	0	0.000000		102.00
200.00	Subtotal (sum of lines 50 thru 199)	6,150,725	25,143,748			200.00
201.00	Less Observation Beds	0	0			201.00
202.00	Total (line 200 minus line 201)	6,150,725	25,143,748			202.00

		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	1,032,837		0	1,032,837	11,123
200.00	Total (lines 30 through 199)	1,032,837			1,032,837	11,123
						92.86
						30.00
						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	5,185	481,479			30.00
200.00	Total (lines 30 through 199)	5,185	481,479			200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-2025

Period:

From 09/01/2022

To 08/31/2023

Worksheet D

Part II

Date/Time Prepared:

1/30/2024 9:16 pm

Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Title XVIII		Hospital		Capital Costs (column 3 x column 4)
		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	PPS	
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	3,098	2,369,454	0.001307	988,358	1,292 50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,654	1,638,421	0.001010	805,052	813 54.00
60.00 06000	LABORATORY	2,272	1,518,129	0.001497	822,817	1,232 60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0 62.30
65.00 06500	RESPIRATORY THERAPY	34,011	13,542,211	0.002511	6,222,773	15,625 65.00
66.00 06600	PHYSICAL THERAPY	13,813	385,780	0.035805	186,321	6,671 66.00
67.00 06700	OCCUPATIONAL THERAPY	13,041	253,995	0.051344	117,724	6,044 67.00
68.00 06800	SPEECH PATHOLOGY	12,637	692,731	0.018242	301,439	5,499 68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	85,487	1,934,979	0.044180	848,394	37,482 71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	14,660	2,144,471	0.006836	847,555	5,794 73.00
74.00 07400	RENAL DIALYSIS	3,012	663,577	0.004539	234,270	1,063 74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0.000000	0	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0 76.98
76.99 07699	LI THOTRI PSY	0	0	0.000000	0	0 76.99
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0 77.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0 92.00
200.00	Total (Lines 50 through 199)	183,685	25,143,748	11,374,703	81,515	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet D
Part III
Date/Time Prepared:
1/30/2024 9:16 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	30.00
200.00		Total (Lines 30 through 199)	0	0	0	0	200.00
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	11,123	0.00	5,185
200.00		Total (Lines 30 through 199)	0	0	11,123	0.00	5,185
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
200.00		Total (Lines 30 through 199)	0				200.00

APPORTMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet D
Part IV
Date/Time Prepared:
1/30/2024 9:16 pm

Cost Center Description	Non Physician Anesthetist Cost	Title XVIII		Hospital	Allied Health
		Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	
	1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0
60.00 06000	LABORATORY	0	0	0	0
62.30 06250	BLOOD CLOTTING FOR HEMOPHILICS	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	0	0	0	0
66.00 06600	PHYSICAL THERAPY	0	0	0	0
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0
74.00 07400	RENAL DIALYSIS	0	0	0	0
76.97 07697	CARDIAC REHABILITATION	0	0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0
76.99 07699	LI THOTRI PSY	0	0	0	0
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0
200.00	Total (Lines 50 through 199)	0	0	0	0

APPORTMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet D
Part IV
Date/Time Prepared:
1/30/2024 9:16 pm

Cost Center Description	All Other Medical Education Cost	Title XVIII		Hospital	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	PPS
		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)		
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	2,369,454	0.000000
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,638,421	0.000000
60.00 06000	LABORATORY	0	0	0	1,518,129	0.000000
62.30 06250	BLOOD CLOTTING FOR HEMOPHILICS	0	0	0	0	0.000000
65.00 06500	RESPIRATORY THERAPY	0	0	0	13,542,211	0.000000
66.00 06600	PHYSICAL THERAPY	0	0	0	385,780	0.000000
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	253,995	0.000000
68.00 06800	SPEECH PATHOLOGY	0	0	0	692,731	0.000000
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,934,979	0.000000
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,144,471	0.000000
74.00 07400	RENAL DIALYSIS	0	0	0	663,577	0.000000
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0.000000
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000
76.99 07699	LITHOTRIPSY	0	0	0	0	0.000000
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000
200.00	Total (lines 50 through 199)	0	0	0	25,143,748	200.00

APPORTMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet D
Part IV
Date/Time Prepared:
1/30/2024 9:16 pm

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)	Title XVIII	Hospital	PPS
						9.00	10.00	11.00
ANCILLARY SERVICE COST CENTERS								
50.00 05000	OPERATING ROOM	0.000000	988,358	0	0	0	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0.000000	805,052	0	0	0	0	54.00
60.00 06000	LABORATORY	0.000000	822,817	0	0	0	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILICS	0.000000	0	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	0.000000	6,222,773	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0.000000	186,321	0	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0.000000	117,724	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0.000000	301,439	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	848,394	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0.000000	847,555	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0.000000	234,270	0	0	0	0	74.00
76.97 07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99 07699	LI THOTRI PSY	0.000000	0	0	0	0	0	76.99
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
200.00	Total (Lines 50 through 199)		11,374,703	0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-2025

Period:

From 09/01/2022

To 08/31/2023

Worksheet D

Part V

Date/Time Prepared:

1/30/2024 9:16 pm

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Title XVIII		Hospital		PPS Costs (see inst.)	
		Charges		Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0 50.00	
54.00	05400 RADIOL OGY-DIAGNOSTIC	0.000000	0	0	0	0 54.00	
60.00	06000 LABORATORY	0.000000	0	0	0	0 60.00	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILICS	0.000000	0	0	0	0 62.30	
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0 65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	0	0 66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0 67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0 68.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0 71.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0 73.00	
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0 74.00	
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97	
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0 76.98	
76.99	07699 LI THOTRIPSY	0.000000	0	0	0	0 76.99	
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0 77.00	
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0 92.00	
200.00	Subtotal (see instructions)		0	0	0	0 200.00	
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00	
202.00	Net Charges (line 200 - line 201)		0	0	0	0 202.00	

Title XVIII

Hospital

PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Co-ins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Co-ins. (see inst.)	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00 06000 LABORATORY	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILICS	0	0	62.30
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
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99 07699 LI THOTRIPSY	0	0	76.99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	77.00
OUTPATIENT SERVICE COST CENTERS			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00 Subtotal (see instructions)	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	0	202.00

		Title XIX		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	1,032,837		0	1,032,837	11,123
200.00	Total (lines 30 through 199)	1,032,837			1,032,837	11,123
						92.86
						30.00
						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		79	7,336		30.00
200.00	Total (lines 30 through 199)		79	7,336		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet D
Part II
Date/Time Prepared:
1/30/2024 9:16 pm

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	Title XIX		Hospital PPS
						1.00	2.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM		3,098	2,369,454	0.001307	0	0	50.00
54.00	05400 RADIOLogy-DIAGNOSTIC		1,654	1,638,421	0.001010	0	0	54.00
60.00	06000 LABORATORY		2,272	1,518,129	0.001497	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY		34,011	13,542,211	0.002511	0	0	65.00
66.00	06600 PHYSICAL THERAPY		13,813	385,780	0.035805	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY		13,041	253,995	0.051344	0	0	67.00
68.00	06800 SPEECH PATHOLOGY		12,637	692,731	0.018242	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		85,487	1,934,979	0.044180	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS		14,660	2,144,471	0.006836	0	0	73.00
74.00	07400 RENAL DIALYSIS		3,012	663,577	0.004539	0	0	74.00
76.97	07697 CARDIAC REHABILITATION		0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY		0	0	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY		0	0	0.000000	0	0	76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION		0	0	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0	0	0.000000	0	0	92.00
200.00	Total (Lines 50 through 199)		183,685	25,143,748		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2025

Period:

From 09/01/2022

To 08/31/2023

Worksheet D

Part III

Date/Time Prepared:

1/30/2024 9:16 pm

Cost Center Description		Title XIX		Hospital		PPS
		Nursing Program Post-Stepdown Adjustments	1A	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	0	0	0	0
200.00	Total (Lines 30 through 199)	0	0	0	0	0
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	11,123	0.00	79
200.00	Total (Lines 30 through 199)	0	0	11,123	0.00	79
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	0	0	0	0
200.00	Total (Lines 30 through 199)	0	0	0	0	0

APPORTMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet D
Part IV
Date/Time Prepared:
1/30/2024 9:16 pm

Cost Center Description	Non Physician Anesthetist Cost	Title XIX		Hospital	PPS
		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
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0
60.00 06000	LABORATORY	0	0	0	0
62.30 06250	BLOOD CLOTTING FOR HEMOPHILICS	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	0	0	0	0
66.00 06600	PHYSICAL THERAPY	0	0	0	0
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0
74.00 07400	RENAL DIALYSIS	0	0	0	0
76.97 07697	CARDIAC REHABILITATION	0	0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0
76.99 07699	LI THOTRI PSY	0	0	0	0
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0
200.00	Total (Lines 50 through 199)	0	0	0	0

APPORTMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet D
Part IV
Date/Time Prepared:
1/30/2024 9:16 pm

Cost Center Description	All Other Medical Education Cost	Title XIX		Hospital	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	PPS
		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)		
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	2,369,454	0.000000
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,638,421	0.000000
60.00 06000	LABORATORY	0	0	0	1,518,129	0.000000
62.30 06250	BLOOD CLOTTING FOR HEMOPHILICS	0	0	0	0	0.000000
65.00 06500	RESPIRATORY THERAPY	0	0	0	13,542,211	0.000000
66.00 06600	PHYSICAL THERAPY	0	0	0	385,780	0.000000
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	253,995	0.000000
68.00 06800	SPEECH PATHOLOGY	0	0	0	692,731	0.000000
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,934,979	0.000000
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,144,471	0.000000
74.00 07400	RENAL DIALYSIS	0	0	0	663,577	0.000000
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0.000000
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000
76.99 07699	LITHOTRIPSY	0	0	0	0	0.000000
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000
200.00	Total (lines 50 through 199)	0	0	0	25,143,748	200.00

APPORTMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet D
Part IV
Date/Time Prepared:
1/30/2024 9:16 pm

Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Title XIX		Hospital		PPS
		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)	
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0.000000	0	0	0	0 50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0 54.00
60.00 06000	LABORATORY	0.000000	0	0	0	0 60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILICS	0.000000	0	0	0	0 62.30
65.00 06500	RESPIRATORY THERAPY	0.000000	0	0	0	0 65.00
66.00 06600	PHYSICAL THERAPY	0.000000	0	0	0	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	0.000000	0	0	0	0 68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0 71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	0.000000	0	0	0	0 74.00
76.97 07697	CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0 76.98
76.99 07699	LI THOTRI PSY	0.000000	0	0	0	0 76.99
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0 77.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0 92.00
200.00	Total (Lines 50 through 199)		0	0	0	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-2025

Period:

From 09/01/2022

To 08/31/2023

Worksheet D

Part V

Date/Time Prepared:

1/30/2024 9:16 pm

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Title XIX		Hospital		PPS Costs (see inst.)	
		Charges		Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.186260	0	0	0	0 50.00	
54.00	05400 RADIOL OGY-DIAGNOSTIC	0.143821	0	0	0	0 54.00	
60.00	06000 LABORATORY	0.213184	0	0	0	0 60.00	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILICS	0.000000	0	0	0	0 62.30	
65.00	06500 RESPIRATORY THERAPY	0.129869	0	0	0	0 65.00	
66.00	06600 PHYSICAL THERAPY	0.768018	0	0	0	0 66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.733420	0	0	0	0 67.00	
68.00	06800 SPEECH PATHOLOGY	0.200636	0	0	0	0 68.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.130305	0	0	0	0 71.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.973919	0	0	0	0 73.00	
74.00	07400 RENAL DIALYSIS	0.646746	0	0	0	0 74.00	
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97	
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0 76.98	
76.99	07699 LI THOTRIPSY	0.000000	0	0	0	0 76.99	
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0 77.00	
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0 92.00	
200.00	Subtotal (see instructions)		0	0	0	0 200.00	
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00	
202.00	Net Charges (line 200 - line 201)		0	0	0	0 202.00	

Cost Center Description	Costs		Title XIX	Hospital	PPS
	Cost Reimbursed Services Subject To Ded. & Co-ins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Co-ins. (see inst.)			
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	0			50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
60.00 06000 LABORATORY	0	0			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILICS	0	0			62.30
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
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
74.00 07400 RENAL DIALYSIS	0	0			74.00
76.97 07697 CARDIAC REHABILITATION	0	0			76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0			76.98
76.99 07699 LI THOTRIPSY	0	0			76.99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0			77.00
OUTPATIENT SERVICE COST CENTERS					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0			92.00
200.00 Subtotal (see instructions)	0	0			200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0				201.00
202.00 Net Charges (Line 200 - Line 201)	0	0			202.00

PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,123	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,123	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)	11,123	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	5,185	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	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)	11,847,389	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)	11,847,389	27.00
PRI VATE 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)	11,847,389	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,065.13	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,522,699	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	5,522,699	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-2025

Worksheet D-1

Period:
From 09/01/2022
To 08/31/2023Date/Time Prepared:
1/30/2024 9:16 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	PPS
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,660,863	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)					8,183,562	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)					481,479	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					81,515	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					562,994	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,620,568	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)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet D-1
Date/Time Prepared:
1/30/2024 9:16 pm

Title XVIII

Hospital

PPS

Cost Center Description

1.00

89.00 Observation bed cost (line 87 x line 88) (see instructions)

0 89.00

Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
	1.00	2.00	3.00	4.00	5.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

90.00 Capital-related cost	1,032,837	11,847,389	0.087178	0	0	90.00
91.00 Nursing Program cost	0	11,847,389	0.000000	0	0	91.00
92.00 Allied health cost	0	11,847,389	0.000000	0	0	92.00
93.00 All other Medical Education	0	11,847,389	0.000000	0	0	93.00

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,123	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,123	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)	11,123	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	79	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00

SWING BED ADJUSTMENT

17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	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)	11,847,389	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)	11,847,389	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)	11,847,389	37.00

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS

38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,065.13	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	84,145	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)	84,145	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-2025

Worksheet D-1

Period:
From 09/01/2022
To 08/31/2023Date/Time Prepared:
1/30/2024 9:16 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	PPS
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	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)					84,145	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)					7,336	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					7,336	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					76,809	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)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet D-1
Date/Time Prepared:
1/30/2024 9:16 pm

Title XIX Hospital

PPS

Cost Center Description

1.00

89.00 Observation bed cost (line 87 x line 88) (see instructions)

0 89.00

Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
	1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
90.00 Capital-related cost	1,032,837	11,847,389	0.087178	0	0 90.00
91.00 Nursing Program cost	0	11,847,389	0.000000	0	0 91.00
92.00 Allied health cost	0	11,847,389	0.000000	0	0 92.00
93.00 All other Medical Education	0	11,847,389	0.000000	0	0 93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-2025

Worksheet D-3

Period:
From 09/01/2022
To 08/31/2023Date/Time Prepared:
1/30/2024 9:16 pm

		Title XVIII	Hospital	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			9,244,270
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.186260	988,358	184,092
54.00	05400 RADIOLogy-DIAGNOSTIC	0.143821	805,052	115,783
60.00	06000 LABORATORY	0.213184	822,817	175,411
62.30	06250 BLOOD CLOTTING FOR HEMOPHILICS	0.000000	0	0
65.00	06500 RESPIRATORY THERAPY	0.129869	6,222,773	808,145
66.00	06600 PHYSICAL THERAPY	0.768018	186,321	143,098
67.00	06700 OCCUPATIONAL THERAPY	0.733420	117,724	86,341
68.00	06800 SPEECH PATHOLOGY	0.200636	301,439	60,480
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.130305	848,394	110,550
73.00	07300 DRUGS CHARGED TO PATIENTS	0.973919	847,555	825,450
74.00	07400 RENAL DIALYSIS	0.646746	234,270	151,513
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0
76.99	07699 LITHOTRIPSY	0.000000	0	0
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0
OUTPATIENT SERVICE COST CENTERS				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0
200.00	Total (sum of lines 50 through 94 and 96 through 98)		11,374,703	2,660,863
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net charges (line 200 minus line 201)		11,374,703	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-2025

Worksheet D-3

Period:
From 09/01/2022
To 08/31/2023

Date/Time Prepared:

1/30/2024 9:16 pm

Cost Center Description	Title XIX	Hospital		PPS
		Ratio of Cost To Charges	Inpatient Program Charges	
		1.00	2.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.186260	0	50.00
54.00	05400 RADIOLogy-DIAGNOSTIC	0.143821	0	54.00
60.00	06000 LABORATORY	0.213184	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILICS	0.000000	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.129869	0	65.00
66.00	06600 PHYSICAL THERAPY	0.768018	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.733420	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.200636	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.130305	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.973919	0	73.00
74.00	07400 RENAL DIALYSIS	0.646746	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
OUTPATIENT SERVICE COST CENTERS				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	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)		0	202.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet E-1
Part I
Date/Time Prepared:
1/30/2024 9:16 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			11,158,095	0
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	1.00
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	2.00
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/31/2023	204,030		0
3.02			0		3.01
3.03			0		3.02
3.04			0		3.03
3.05			0		3.04
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		3.50
3.52			0		3.51
3.53			0		3.52
3.54			0		3.53
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		204,030		3.54
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)		11,362,125		3.99
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)				4.00
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		5.01
5.03			0		5.02
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		5.50
5.52			0		5.51
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		5.52
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				5.99
6.01	SETTLEMENT TO PROVIDER		0		6.00
6.02	SETTLEMENT TO PROGRAM		2,460		6.01
7.00	Total Medicare program liability (see instructions)		11,359,665		6.02
				Contractor Number	NPR Date (Mo/Day/Yr)
8.00	Name of Contractor		0	1.00	2.00
					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet E-3
Part IV
Date/Time Prepared:
1/30/2024 9:16 pm

Title XVIII		Hospital	PPS
		1.00	
PART IV - MEDICARE PART A SERVICES - LTCH PPS			
1.00	Net Federal PPS Payments (see instructions)	11,840,426	1.00
1.01	Full standard payment amount	9,773,126	1.01
1.02	Short stay outlier standard payment amount	2,067,300	1.02
1.03	Site neutral payment amount - Cost	0	1.03
1.04	Site neutral payment amount - IPPS comparable	0	1.04
2.00	Outlier Payments	14,372	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)	11,854,798	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)	0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)	0	6.00
7.00	Subtotal (see instructions)	11,854,798	7.00
8.00	Primary payer payments	0	8.00
9.00	Subtotal (line 7 less line 8).	11,854,798	9.00
10.00	Deductibles	83,336	10.00
11.00	Subtotal (line 9 minus line 10)	11,771,462	11.00
12.00	Coinurance	385,651	12.00
13.00	Subtotal (line 11 minus line 12)	11,385,811	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	316,437	14.00
15.00	Adjusted reimbursable bad debts (see instructions)	205,684	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	236,516	16.00
17.00	Subtotal (sum of lines 13 and 15)	11,591,495	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	18.00
19.00	Other pass through costs (see instructions)	0	19.00
20.00	Outlier payments reconciliation	0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	21.50
21.98	Recovery of accelerated depreciation.	0	21.98
21.99	Demonstration payment adjustment amount before sequestration	0	21.99
22.00	Total amount payable to the provider (see instructions)	11,591,495	22.00
22.01	Sequestration adjustment (see instructions)	231,830	22.01
22.02	Demonstration payment adjustment amount after sequestration	0	22.02
23.00	Interim payments	11,362,125	23.00
24.00	Tentative settlement (for contractor use only)	0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)	-2,460	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	26.00
TO BE COMPLETED BY CONTRACTOR			
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)	14,372	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money (see instructions)	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

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

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023

Worksheet G
Date/Time Prepared:
1/30/2024 9:16 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
					1. 00
CURRENT ASSETS					
1.00	Cash on hand in banks	-104, 578	0	0	0
2.00	Temporary investments	0	0	0	2. 00
3.00	Notes receivable	0	0	0	3. 00
4.00	Accounts receivable	3, 658, 791	0	0	4. 00
5.00	Other receivable	0	0	0	5. 00
6.00	All allowances for uncollectible notes and accounts receivable	0	0	0	6. 00
7.00	Inventory	0	0	0	7. 00
8.00	Prepaid expenses	230, 309	0	0	8. 00
9.00	Other current assets	0	0	0	9. 00
10.00	Due from other funds	0	0	0	10. 00
11.00	Total current assets (sum of lines 1-10)	3, 784, 522	0	0	11. 00
FIXED ASSETS					
12.00	Land	0	0	0	12. 00
13.00	Land improvements	0	0	0	13. 00
14.00	Accumulated depreciation	0	0	0	14. 00
15.00	Buildings	0	0	0	15. 00
16.00	Accumulated depreciation	0	0	0	16. 00
17.00	Leasehold improvements	110, 439	0	0	17. 00
18.00	Accumulated depreciation	0	0	0	18. 00
19.00	Fixed equipment	0	0	0	19. 00
20.00	Accumulated depreciation	0	0	0	20. 00
21.00	Automobiles and trucks	0	0	0	21. 00
22.00	Accumulated depreciation	0	0	0	22. 00
23.00	Major movable equipment	1, 785, 181	0	0	23. 00
24.00	Accumulated depreciation	-1, 220, 809	0	0	24. 00
25.00	Minor equipment-depreciable	0	0	0	25. 00
26.00	Accumulated depreciation	0	0	0	26. 00
27.00	HIT designated Assets	0	0	0	27. 00
28.00	Accumulated depreciation	0	0	0	28. 00
29.00	Minor equipment-nondepreciable	1, 556, 298	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	2, 231, 109	0	0	30. 00
OTHER ASSETS					
31.00	Investments	0	0	0	31. 00
32.00	Deposits on leases	180, 200	0	0	32. 00
33.00	Due from owners/officers	0	0	0	33. 00
34.00	Other assets	0	0	0	34. 00
35.00	Total other assets (sum of lines 31-34)	180, 200	0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	6, 195, 831	0	0	36. 00
CURRENT LIABILITIES					
37.00	Accounts payable	1, 173, 207	0	0	37. 00
38.00	Salaries, wages, and fees payable	542, 770	0	0	38. 00
39.00	Payroll taxes payable	0	0	0	39. 00
40.00	Notes and loans payable (short term)	0	0	0	40. 00
41.00	Deferred income	0	0	0	41. 00
42.00	Accelerated payments	0	0	0	42. 00
43.00	Due to other funds	0	0	0	43. 00
44.00	Other current liabilities	0	0	0	44. 00
45.00	Total current liabilities (sum of lines 37 thru 44)	1, 715, 977	0	0	45. 00
LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	46. 00
47.00	Notes payable	221, 901	0	0	47. 00
48.00	Unsecured loans	0	0	0	48. 00
49.00	Other long term liabilities	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	221, 901	0	0	50. 00
51.00	Total liabilities (sum of lines 45 and 50)	1, 937, 878	0	0	51. 00
CAPITAL ACCOUNTS					
52.00	General fund balance	4, 257, 953	0	0	52. 00
53.00	Specific purpose fund				53. 00
54.00	Donor created - endowment fund balance - restricted				54. 00
55.00	Donor created - endowment fund balance - unrestricted				55. 00
56.00	Governing body created - endowment fund balance				56. 00
57.00	Plant fund balance - invested in plant				57. 00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				58. 00
59.00	Total fund balances (sum of lines 52 thru 58)	4, 257, 953	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	6, 195, 831	0	0	60. 00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet G-1
Date/Time Prepared:
1/30/2024 9:16 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1. 00	2. 00	3. 00	4. 00	
					5. 00	
1. 00	Fund balances at beginning of period		1,159,276		0	1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)		5,417,221		0	2. 00
3. 00	Total (sum of line 1 and line 2)		6,576,497		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)		6,576,497		0	11. 00
12. 00	Deductions (debit adjustments) (specify)	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)		6,576,497		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)	0		0		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	Deductions (debit adjustments) (specify)		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: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet G-2
Parts I & II
Date/Time Prepared:
1/30/2024 9:16 pm

Cost Center Description	Inpatient	Outpatient	Total	
	1.00	2.00	3.00	
PART I - PATIENT REVENUES				
General Inpatient Routine Services				
1.00 Hospital			19,883,010	19,883,010
2.00 SUBPROVIDER - IPF				1.00
3.00 SUBPROVIDER - IRF				2.00
4.00 SUBPROVIDER				3.00
5.00 Swinging bed - SNF	0			4.00
6.00 Swinging bed - NF	0			5.00
7.00 SKILLED NURSING FACILITY				6.00
8.00 NURSING FACILITY				7.00
9.00 OTHER LONG TERM CARE				8.00
10.00 Total general inpatient care services (sum of lines 1-9)	19,883,010		19,883,010	9.00
Intensive Care Type Inpatient Hospital Services				
11.00 INTENSIVE CARE UNIT				10.00
12.00 CORONARY CARE UNIT				11.00
13.00 BURN INTENSIVE CARE UNIT				12.00
14.00 SURGICAL INTENSIVE CARE UNIT				13.00
15.00 OTHER SPECIAL CARE (SPECIFY)				14.00
16.00 Total intensive care type inpatient hospital services (sum of lines 11-15)	0			15.00
17.00 Total inpatient routine care services (sum of lines 10 and 16)	19,883,010		19,883,010	16.00
18.00 Ancillary services	25,143,748	0	25,143,748	17.00
19.00 Outpatient services	0	0	0	18.00
20.00 RURAL HEALTH CLINIC	0	0	0	19.00
21.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	20.00
22.00 HOME HEALTH AGENCY	0	0	0	21.00
23.00 AMBULANCE SERVICES	0	0	0	22.00
24.00 CMHC	0	0	0	23.00
24.10 CORF	0	0	0	24.00
24.20 OUTPATIENT PHYSICAL THERAPY	0	0	0	24.10
24.30 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.20
24.40 OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.30
25.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	24.40
26.00 HOSPICE	0	0	0	25.00
27.00 OTHER (SPECIFY)	0	0	0	26.00
28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. G-3, line 1)	45,026,758	0	45,026,758	27.00
PART II - OPERATING EXPENSES				
29.00 Operating expenses (per Wkst. A, column 3, line 200)			19,256,247	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)		19,256,247		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-2025

Period:
From 09/01/2022
To 08/31/2023Worksheet G-3
Date/Time Prepared:
1/30/2024 9:16 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	45,026,758	1.00
2.00	Less contractual allowances and discounts on patients' accounts	20,357,313	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,669,445	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	19,256,247	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,413,198	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	3,213	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	810	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 (SPECIFY)	0	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	4,023	25.00
26.00	Total (line 5 plus line 25)	5,417,221	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,417,221	29.00