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: 15-1318	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/31/2024 10:49 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/31/2024 Time: 10:49 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DUKES MEMORIAL HOSPITAL (15-1318) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 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		2		
1				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title	VICE PRESIDENT, REVENUE MANAGEMEN			3
4	Date				4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	752,249	-148,004	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	541,280	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	1,293,529	-148,004	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 10:49 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 275 WEST 12TH STREET	PO Box:			1.00
2.00	City: PERU	State: IN	Zip Code: 46970	County: MIAMI	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	DUKES MEMORIAL HOSPITAL	151318	99915	1	07/01/1966	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	DUKES MEMORIAL HOSPITAL SB	15Z318	99915		12/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	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			22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2024 10:49 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 10:49 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 10:49 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1318	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 10:49 am

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

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 10:49 am

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2024 10:49 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	23,139	19,086	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	N		123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB1848	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WPS	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 10:49 am

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

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

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		0.00	169.00
		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2024 10:49 am

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

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

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

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

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/14/2024	Y	04/14/2024	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2024 10:49 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			Y	12/31/2022	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KUZIWA		TSIGA		41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS, INC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-3416		KUZIWA_TSIGA@CHS.NET		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1318	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/31/2024 10:49 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER, REVENUE MANAGEMENT		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: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2024 10:49 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	45,568.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	45,568.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	3,824.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	49,392.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2024 10:49 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	833	71	1,899			1.00
2.00	HMO and other (see instructions)	559	450				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	755	0	1,131			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	1			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,588	71	3,031			7.00
8.00	INTENSIVE CARE UNIT	64	6	159			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		16	237			13.00
14.00	Total (see instructions)	1,652	93	3,427	0.00	189.64	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			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)			2			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	189.64	27.00
28.00	Observation Bed Days		0	597			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			1			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2024 10:49 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	264	26	676	1.00
2.00	HMO and other (see instructions)			156	111		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	264	26	676	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part IV | Date/Time Prepared: 5/31/2024 10:49 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	241,299	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	2,162,175	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	4,907	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	17,205	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)	5,526	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	88,646	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	802,646	17.00
18.00	Medicare Taxes - Employers Portion Only	187,716	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	30,501	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,540,621	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1318	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/31/2024 10:49 am

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.217330	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,243,535	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	46,660,373	6.00
7.00	Medicaid cost (line 1 times line 6)	10,140,699	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	3,897,164	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,897,164	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	2,423,042	7,667	2,430,709	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	526,600	7,667	534,267	21.00
22.00	Payments received from patients for amounts previously written off as charity care	917	0	917	22.00
23.00	Cost of charity care (see instructions)	525,683	7,667	533,350	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	2,121,313	26.00
27.00	Medicare reimbursable bad debts (see instructions)	289,368	27.00
27.01	Medicare allowable bad debts (see instructions)	445,181	27.01
28.00	Non-Medicare bad debt amount (see instructions)	1,676,132	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	520,087	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	1,053,437	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,950,601	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1318	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/31/2024 10:49 am

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)		1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		5.00
6.00	Medicaid charges		6.00
7.00	Medicaid cost (line 1 times line 6)		7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP		9.00
10.00	Stand-alone CHIP charges		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)				20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)				21.00
22.00	Payments received from patients for amounts previously written off as charity care				22.00
23.00	Cost of charity care (see instructions)				23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		25.00
25.01	Charges for insured patients' liability (see instructions)		25.01
26.00	Bad debt amount (see instructions)		26.00
27.00	Medicare reimbursable bad debts (see instructions)		27.00
27.01	Medicare allowable bad debts (see instructions)		27.01
28.00	Non-Medicare bad debt amount (see instructions)		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/31/2024 10:49 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,117,018	1,117,018	1,252,244	2,369,262	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,401,489	2,401,489	173,671	2,575,160	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	94,502	98,176	192,678	2,579,507	2,772,185	4.00
5.01	00570	ADMITTING	0	-95	-95	1,441,318	1,441,223	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	1,733,392	11,592,914	13,326,306	-4,712,237	8,614,069	5.02
7.00	00700	OPERATION OF PLANT	386,822	1,888,038	2,274,860	407,012	2,681,872	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	132,234	132,234	0	132,234	8.00
9.00	00900	HOUSEKEEPING	389,501	161,528	551,029	-1,401	549,628	9.00
10.00	01000	DIETARY	237,934	177,256	415,190	-86,781	328,409	10.00
11.00	01100	CAFETERIA	0	0	0	86,781	86,781	11.00
13.00	01300	NURSING ADMINISTRATION	624,623	94,705	719,328	-22,265	697,063	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	178,670	217,444	396,114	-117,950	278,164	14.00
15.00	01500	PHARMACY	508,533	1,040,414	1,548,947	-938,595	610,352	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	40,088	246,333	286,421	-309	286,112	16.00
17.00	01700	SOCIAL SERVICE	194,304	15,965	210,269	0	210,269	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,692,385	1,043,475	3,735,860	-300,729	3,435,131	30.00
31.00	03100	INTENSIVE CARE UNIT	325,684	28,233	353,917	0	353,917	31.00
43.00	04300	NURSERY	0	0	0	316,137	316,137	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	497,949	757,636	1,255,585	-286,672	968,913	50.00
51.00	05100	RECOVERY ROOM	231,646	39,341	270,987	0	270,987	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	300,647	300,647	0	300,647	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	729,339	481,806	1,211,145	240,641	1,451,786	54.00
54.01	05401	ULTRASOUND	106,796	91,910	198,706	-198,706	0	54.01
56.00	05600	RADIOISOTOPE	99,541	71,193	170,734	-170,734	0	56.00
57.00	05700	CT SCAN	0	128,589	128,589	-128,589	0	57.00
58.00	05800	MRI	95,994	211,727	307,721	-307,721	0	58.00
60.00	06000	LABORATORY	987,381	839,945	1,827,326	-68,816	1,758,510	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	62,833	62,833	0	62,833	62.00
65.00	06500	RESPIRATORY THERAPY	496,397	102,770	599,167	-24,732	574,435	65.00
66.00	06600	PHYSICAL THERAPY	0	352,249	352,249	0	352,249	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	235,953	235,953	0	235,953	67.00
68.00	06800	SPEECH PATHOLOGY	0	94,642	94,642	0	94,642	68.00
69.00	06900	ELECTROCARDIOLOGY	130,762	44,891	175,653	-1,764	173,889	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	85,866	85,866	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	106,730	106,730	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	822,255	822,255	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	377,633	377,633	0	377,633	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	107,120	13,105	120,225	0	120,225	90.00
91.00	09100	EMERGENCY	4,067,504	1,679,255	5,746,759	-1,162	5,745,597	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	275,969	365,914	641,883	-142,999	498,884	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,232,836	26,507,166	41,740,002	0	41,740,002	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	15,232,836	26,507,166	41,740,002	0	41,740,002	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/31/2024 10:49 am

		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	417,166	2,786,428		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	65,454	2,640,614		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,772,185		4.00
5.01	00570	ADMITTING	0	1,441,223		5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	-450,271	8,163,798		5.02
7.00	00700	OPERATION OF PLANT	-12,613	2,669,259		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	132,234		8.00
9.00	00900	HOUSEKEEPING	0	549,628		9.00
10.00	01000	DIETARY	0	328,409		10.00
11.00	01100	CAFETERIA	-68,304	18,477		11.00
13.00	01300	NURSING ADMINISTRATION	36,818	733,881		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	278,164		14.00
15.00	01500	PHARMACY	0	610,352		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-135	285,977		16.00
17.00	01700	SOCIAL SERVICE	0	210,269		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-679,048	2,756,083		30.00
31.00	03100	INTENSIVE CARE UNIT	0	353,917		31.00
43.00	04300	NURSERY	0	316,137		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	968,913		50.00
51.00	05100	RECOVERY ROOM	0	270,987		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	-300,647	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-226,082	1,225,704		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	1,758,510		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	62,833		62.00
65.00	06500	RESPIRATORY THERAPY	0	574,435		65.00
66.00	06600	PHYSICAL THERAPY	0	352,249		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	235,953		67.00
68.00	06800	SPEECH PATHOLOGY	0	94,642		68.00
69.00	06900	ELECTROCARDIOLOGY	0	173,889		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	85,866		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	106,730		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	822,255		73.00
76.00	03610	SLEEP LAB	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	377,633		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	120,225		90.00
91.00	09100	EMERGENCY	-282,779	5,462,818		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	498,884		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,500,441	40,239,561		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,500,441	40,239,561		200.00

RECLASSIFICATIONS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/31/2024 10:49 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,579,507		1.00
	TOTALS		0	2,579,507		
	B - RENT AND LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	623,869		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	159,962		2.00
3.00	ADMITTING	5.01	0	75		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
	TOTALS		0	783,906		
	C - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	191,319		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	437,056		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	13,709		3.00
	TOTALS		0	642,084		
	D - REPAIRS AND MAINTENANCE					
1.00	OPERATION OF PLANT	7.00	0	410,811		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
	TOTALS		0	410,811		
	E - CNO COSTS					
1.00	NURSING ADMINISTRATION	13.00	197,437	0		1.00
	TOTALS		197,437	0		
	F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	85,866		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	106,730		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		0	192,596		
	G - COST OF DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	822,255		1.00
	TOTALS		0	822,255		
	H - NURSERY					
1.00	NURSERY	43.00	276,819	39,318		1.00
	TOTALS		276,819	39,318		
	I - QUALITY ASSURANCE					
1.00	ADMINISTRATIVE AND GENERAL	5.02	166,518	36,052		1.00
	TOTALS		166,518	36,052		
	J - MISC DEPARTMENTS					
1.00	ADMITTING	5.01	580,409	860,834		1.00
	TOTALS		580,409	860,834		
	K - OTHER RADIOLOGY					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	302,331	90,721		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		302,331	90,721		

RECLASSIFICATIONS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/31/2024 10:49 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	L - DIETARY COSTS TO CAFETERIA					
1.00	CAFETERIA	11.00	49,301	37,480		1.00
	TOTALS		49,301	37,480		
	M - NON CAPITALIZED EQUIPMENT					
1.00	OPERATION OF PLANT	7.00	0	956		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	956		
	N - SITTER COSTS					
1.00	ADULTS & PEDIATRICS	30.00	15,850	1,238		1.00
	TOTALS		15,850	1,238		
500.00	Grand Total: Increases		1,588,665	6,497,758		500.00

RECLASSIFICATIONS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/31/2024 10:49 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE AND GENERAL	5.02	0	2,579,507	0		1.00
	TOTALS		0	2,579,507			
	B - RENT AND LEASES						
1.00	ADMINISTRATIVE AND GENERAL	5.02	0	459	10		1.00
2.00	OPERATION OF PLANT	7.00	0	4,755	10		2.00
3.00	NURSING ADMINISTRATION	13.00	0	44	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	87,231	0		4.00
5.00	PHARMACY	15.00	0	114,420	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	309	0		6.00
7.00	OPERATING ROOM	50.00	0	104,337	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	84,573	0		8.00
9.00	ULTRASOUND	54.01	0	33,243	0		9.00
10.00	CT SCAN	57.00	0	72,155	0		10.00
11.00	MRI	58.00	0	127,153	0		11.00
12.00	LABORATORY	60.00	0	35,604	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	17,194	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	1,764	0		14.00
15.00	AMBULANCE SERVICES	95.00	0	100,665	0		15.00
	TOTALS		0	783,906			
	C - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE AND GENERAL	5.02	0	642,084	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	642,084			
	D - REPAIRS AND MAINTENANCE						
1.00	ADMINISTRATIVE AND GENERAL	5.02	0	54,077	0		1.00
2.00	HOUSEKEEPING	9.00	0	1,401	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,814	0		3.00
4.00	PHARMACY	15.00	0	1,920	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	1,173	0		5.00
6.00	OPERATING ROOM	50.00	0	17,824	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	67,838	0		7.00
8.00	ULTRASOUND	54.01	0	50,298	0		8.00
9.00	RADIOISOTOPE	56.00	0	14,399	0		9.00
10.00	CT SCAN	57.00	0	45,000	0		10.00
11.00	MRI	58.00	0	70,450	0		11.00
12.00	LABORATORY	60.00	0	33,212	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	7,266	0		13.00
14.00	EMERGENCY	91.00	0	805	0		14.00
15.00	AMBULANCE SERVICES	95.00	0	42,334	0		15.00
	TOTALS		0	410,811			
	E - CNO COSTS						
1.00	ADMINISTRATIVE AND GENERAL	5.02	197,437	0	0		1.00
	TOTALS		197,437	0			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	27,905	0		1.00
2.00	OPERATING ROOM	50.00	0	164,174	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	160	0		3.00
4.00	EMERGENCY	91.00	0	357	0		4.00
	TOTALS		0	192,596			
	G - COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	822,255	0		1.00
	TOTALS		0	822,255			
	H - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	276,819	39,318	0		1.00
	TOTALS		276,819	39,318			
	I - QUALITY ASSURANCE						
1.00	NURSING ADMINISTRATION	13.00	166,518	36,052	0		1.00
	TOTALS		166,518	36,052			
	J - MISC DEPARTMENTS						
1.00	ADMINISTRATIVE AND GENERAL	5.02	580,409	860,834	0		1.00
	TOTALS		580,409	860,834			
	K - OTHER RADIOLOGY						
1.00	ULTRASOUND	54.01	106,796	8,369	0		1.00
2.00	RADIOISOTOPE	56.00	99,541	56,794	0		2.00
3.00	CT SCAN	57.00	0	11,434	0		3.00
4.00	MRI	58.00	95,994	14,124	0		4.00
	TOTALS		302,331	90,721			
	L - DIETARY COSTS TO CAFETERIA						
1.00	DIETARY	10.00	49,301	37,480	0		1.00
	TOTALS		49,301	37,480			

RECLASSIFICATIONS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/31/2024 10:49 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	M - NON CAPITALIZED EQUIPMENT						
1.00	ADULTS & PEDIATRICS	30.00	0	507	0		1.00
2.00	OPERATING ROOM	50.00	0	337	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	112	0		3.00
	TOTALS		0	956			
	N - SITTER COSTS						
1.00	NURSING ADMINISTRATION	13.00	15,850	1,238	0		1.00
	TOTALS		15,850	1,238			
500.00	Grand Total: Decreases		1,588,665	6,497,758			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/31/2024 10:49 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	193,225	0	0	0	0	1.00
2.00	Land Improvements	1,038,384	0	0	0	0	2.00
3.00	Buildings and Fixtures	29,476,515	828,589	0	828,589	0	3.00
4.00	Building Improvements	33,715,391	438,925	0	438,925	316,935	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	4,592,929	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	69,016,444	1,267,514	0	1,267,514	316,935	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	69,016,444	1,267,514	0	1,267,514	316,935	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	193,225	0	1.00
2.00	Land Improvements	1,038,384	0	2.00
3.00	Buildings and Fixtures	30,305,104	0	3.00
4.00	Building Improvements	33,837,381	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	4,592,929	0	7.00
8.00	Subtotal (sum of lines 1-7)	69,967,023	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	69,967,023	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/31/2024 10:49 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,117,018	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,401,489	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,518,507	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,117,018	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,401,489	2.00
3.00	Total (sum of lines 1-2)	0	3,518,507	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 5/31/2024 10:49 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	65,374,093	0	65,374,093	0.934356	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,592,929	0	4,592,929	0.065644	0	2.00
3.00	Total (sum of lines 1-2)	69,967,022	0	69,967,022	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	1,498,878	658,795	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,417,891	208,201	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,916,769	866,996	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	380	191,319	437,056	0	2,786,428	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	813	13,709	0	0	2,640,614	2.00
3.00	Total (sum of lines 1-2)	1,193	205,028	437,056	0	5,427,042	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/31/2024 10:49 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-12,613	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,483,432			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	-325,173			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-68,304	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-135	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	A	635	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-2,472	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)	A	-8,290	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	FITNESS REVENUE	B	-135	ADMINISTRATIVE AND GENERAL	5.02	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/31/2024 10:49 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISCELLANEOUS INCOME	B	-14,535	ADMINISTRATIVE AND GENERAL	5.02	0	33.01
33.02	EMPLOYEE SELF INS DISCOUNTS	B	36,818	NURSING ADMINISTRATION	13.00	0	33.02
33.03	PHYSICIAN RECRUITING	A	-2,580	ADMINISTRATIVE AND GENERAL	5.02	0	33.03
33.04	POB CAPITAL RELATED EXPENSE	A	381,225	CAP REL COSTS-BLDG & FIXT	1.00	9	33.04
33.05	POB CAPITAL RELATED EXPENSE	A	19,824	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.05
33.06	CHARITABLE CONTRIBUTIONS	A	-1,730	ADMINISTRATIVE AND GENERAL	5.02	0	33.06
33.07	PATIENT TV DEPRECIATION	A	-950	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.07
33.08	INTEREST INCOME ADD BACK	B	5,501	ADMINISTRATIVE AND GENERAL	5.02	0	33.08
33.09	NON-ALLOWABLE LEGAL FEES	A	-639	ADMINISTRATIVE AND GENERAL	5.02	0	33.09
33.11	MARKETING EXPENSE	A	-3,526	ADMINISTRATIVE AND GENERAL	5.02	0	33.11
34.00	LOBBYING EXPENSE	A	-4,364	ADMINISTRATIVE AND GENERAL	5.02	0	34.00
35.00	EMERGENCY ROOM STAND-BY EXPENSE	A	984,434	EMERGENCY	91.00	0	35.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,500,441				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: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/31/2024 10:49 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	380	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	813	0	2.00
3.00	5.02	ADMINISTRATIVE AND GENERAL	PASI OPERATING COSTS	238,640	177,543	3.00
3.02	5.02	ADMINISTRATIVE AND GENERAL	SHARED SERVICE CENTER ALLOCA	985,127	761,678	3.02
3.04	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	34,926	0	3.04
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	48,239	0	4.00
4.01	5.02	ADMINISTRATIVE AND GENERAL	NON-CAPITAL HOME OFFICE COST	1,308,642	0	4.01
4.02	5.02	ADMINISTRATIVE AND GENERAL	MALPRACTICE COSTS	42,225	291,594	4.02
4.03	5.02	ADMINISTRATIVE AND GENERAL	MANAGEMENT FEES	0	878,889	4.03
4.04	5.02	ADMINISTRATIVE AND GENERAL	401K FEES	0	5,151	4.04
4.05	5.02	ADMINISTRATIVE AND GENERAL	AUDIT FEES	0	28,023	4.05
4.06	5.02	ADMINISTRATIVE AND GENERAL	CORPORATE OVERHEAD ALLOCATIO	0	612,830	4.06
4.07	5.02	ADMINISTRATIVE AND GENERAL	HIIM ALLOCATION	0	158,097	4.07
4.08	5.02	ADMINISTRATIVE AND GENERAL	CONTRACT MANAGEMENT	0	90,698	4.08
4.09	5.02	ADMINISTRATIVE AND GENERAL	PASI LIEN UNIT COLLECTION FE	0	-20,338	4.09
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,658,992	2,984,165	5.00

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

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

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

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

6.00	B		0.00	COMMUNITY HEALTH SYTEMS	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00	B		0.00	HOSPITAL LAUNDRY SERVICE	100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1318	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Date/Time Prepared: 5/31/2024 10:49 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	380	11		1.00
2.00	813	11		2.00
3.00	61,097	0		3.00
3.02	223,449	0		3.02
3.04	34,926	10		3.04
4.00	48,239	10		4.00
4.01	1,308,642	0		4.01
4.02	-249,369	0		4.02
4.03	-878,889	0		4.03
4.04	-5,151	0		4.04
4.05	-28,023	0		4.05
4.06	-612,830	0		4.06
4.07	-158,097	0		4.07
4.08	-90,698	0		4.08
4.09	20,338	0		4.09
5.00	-325,173			5.00

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

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

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

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

6.00	HOSPITAL MANAGEMENT		6.00
7.00	DEBT COLLECTION		7.00
8.00	LAUNDRY SERVICE		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2024 10:49 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.02	ADMINISTRATIVE AND GENERAL	18,732	18,732	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	670,758	670,758	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	300,647	300,647	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	226,082	226,082	0	0	0	4.00
5.00	91.00	EMERGENCY	2,706,956	1,267,213	1,439,743	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			3,923,175	2,483,432	1,439,743		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.02	ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.02	ADMINISTRATIVE AND GENERAL	0	0	0	18,732		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	670,758		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	300,647		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	226,082		4.00
5.00	91.00	EMERGENCY	0	0	0	1,267,213		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,483,432		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/31/2024 10:49 am

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					0	1.00
2.00	Line 1 multiplied by 15 hours per week					0	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	138.31	3,162.14	1,887.53	1,256.53	0.00	9.00
10.00	AHSEA (see instructions)	81.04	88.98	50.50	17.50	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	44.49	44.49	25.25			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					11,209	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					281,367	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					95,320	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					387,896	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					21,989	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					409,885	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					409,885	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/31/2024 10:49 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	88.98	50.50	17.50	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	409,885		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	409,885		63.00
64.00	Total cost of outside supplier services (from your records)	349,285		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1318	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/31/2024 10:49 am

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

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	1,934.36	110.96	1,835.63	0.00	0.00	9.00
10.00	AHSEA (see instructions)	84.35	84.35	50.50	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	42.18	42.18	25.25			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	163,163	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	9,359	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	92,699	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	265,221	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	265,221	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	265,221	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1318	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/31/2024 10:49 am

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	84.35	50.50	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		265,221	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		265,221	63.00
64.00	Total cost of outside supplier services (from your records)		235,873	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		0	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		0	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/31/2024 10:49 am

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					0	1.00
2.00	Line 1 multiplied by 15 hours per week					0	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,352.03	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	81.07	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.54	40.54	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					109,609	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					109,609	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					109,609	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					109,609	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/31/2024 10:49 am

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	81.07	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	109,609	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	109,609	63.00
64.00	Total cost of outside supplier services (from your records)	94,642	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 10:49 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,786,428	2,786,428				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,640,614		2,640,614			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,772,185	12,712	12,046	2,796,943		4.00
5.01	00570	ADMITTING	1,441,223	20,480	19,408	107,236	1,588,347	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	8,163,798	158,665	150,362	207,311	0	5.02
7.00	00700	OPERATION OF PLANT	2,669,259	755,433	715,902	71,469	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	132,234	32,918	31,195	0	0	8.00
9.00	00900	HOUSEKEEPING	549,628	31,779	30,116	71,964	0	9.00
10.00	01000	DIETARY	328,409	40,859	38,721	34,852	0	10.00
11.00	01100	CAFETERIA	18,477	36,694	34,773	9,109	0	11.00
13.00	01300	NURSING ADMINISTRATION	733,881	10,089	9,561	118,189	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	278,164	51,250	48,568	33,011	0	14.00
15.00	01500	PHARMACY	610,352	29,603	28,054	93,956	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	285,977	47,906	45,399	7,407	0	16.00
17.00	01700	SOCIAL SERVICE	210,269	12,452	11,801	35,899	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,756,083	395,098	374,423	449,226	82,096	30.00
31.00	03100	INTENSIVE CARE UNIT	353,917	49,694	47,093	60,173	6,582	31.00
43.00	04300	NURSERY	316,137	10,795	10,230	51,145	1,363	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	968,913	187,115	177,323	92,001	159,836	50.00
51.00	05100	RECOVERY ROOM	270,987	14,729	13,959	42,799	33,478	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,225,704	157,685	149,433	190,610	346,557	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,758,510	44,260	41,944	182,428	221,804	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62,833	1,701	1,612	0	3,555	62.00
65.00	06500	RESPIRATORY THERAPY	574,435	44,721	42,381	91,714	33,195	65.00
66.00	06600	PHYSICAL THERAPY	352,249	127,606	120,929	0	28,905	66.00
67.00	06700	OCCUPATIONAL THERAPY	235,953	3,473	3,292	0	17,165	67.00
68.00	06800	SPEECH PATHOLOGY	94,642	0	0	0	2,712	68.00
69.00	06900	ELECTROCARDIOLOGY	173,889	58,586	55,520	24,159	54,543	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	85,866	0	0	0	15,901	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	106,730	0	0	0	9,492	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	822,255	0	0	0	186,616	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	377,633	13,620	12,907	0	453	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	120,225	39,173	37,123	19,791	718	90.00
91.00	09100	EMERGENCY	5,462,818	106,204	100,646	751,506	280,181	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	498,884	36,852	34,924	50,988	103,195	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,239,561	2,532,152	2,399,645	2,796,943	1,588,347	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,328	10,735	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	242,948	230,234	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	40,239,561	2,786,428	2,640,614	2,796,943	1,588,347	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 10:49 am

		Cost Center Description	Subtotal	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.01	5.02	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
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	8,680,136	8,680,136				5.02
7.00	00700	OPERATION OF PLANT	4,212,063	1,158,490	5,370,553			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	196,347	54,003	110,950	361,300		8.00
9.00	00900	HOUSEKEEPING	683,487	187,987	107,113	0	978,587	9.00
10.00	01000	DIETARY	442,841	121,799	137,716	0	26,802	10.00
11.00	01100	CAFETERIA	99,053	27,244	123,678	0	24,070	11.00
13.00	01300	NURSING ADMINISTRATION	871,720	239,759	34,004	0	6,618	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	410,993	113,040	172,741	0	33,618	14.00
15.00	01500	PHARMACY	761,965	209,572	99,778	0	19,418	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	386,689	106,355	161,471	0	31,425	16.00
17.00	01700	SOCIAL SERVICE	270,421	74,377	41,971	0	8,168	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,056,926	1,115,821	1,331,696	298,958	259,170	30.00
31.00	03100	INTENSIVE CARE UNIT	517,459	142,322	167,494	25,031	32,597	31.00
43.00	04300	NURSERY	389,670	107,175	36,384	37,311	7,081	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,585,188	435,992	630,678	0	122,741	50.00
51.00	05100	RECOVERY ROOM	375,952	103,402	49,646	0	9,662	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,069,989	569,332	531,483	0	103,436	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,248,946	618,552	149,181	0	29,033	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	69,701	19,171	5,732	0	1,116	62.00
65.00	06500	RESPIRATORY THERAPY	786,446	216,305	150,735	0	29,336	65.00
66.00	06600	PHYSICAL THERAPY	629,689	173,190	430,103	0	83,705	66.00
67.00	06700	OCCUPATIONAL THERAPY	259,883	71,478	11,707	0	2,278	67.00
68.00	06800	SPEECH PATHOLOGY	97,354	26,776	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	366,697	100,857	197,466	0	38,430	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	101,767	27,990	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	116,222	31,966	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,008,871	277,481	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	404,613	111,285	36,433	0	7,090	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	217,030	59,692	132,033	0	25,696	90.00
91.00	09100	EMERGENCY	6,701,355	1,843,149	357,966	0	69,666	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	724,843	199,362	124,212	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,744,316	8,543,924	5,332,371	361,300	971,156	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	22,063	6,068	38,182	0	7,431	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	473,182	130,144	0	0	0	192.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	40,239,561	8,680,136	5,370,553	361,300	978,587	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/31/2024 10:49 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	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-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	729,158					10.00
11.00	01100	CAFETERIA	0	274,045				11.00
13.00	01300	NURSING ADMINISTRATION	0	12,876	1,164,977			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,683	0	738,075		14.00
15.00	01500	PHARMACY	0	9,433	0	15,908	1,116,074	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,879	0	291	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,851	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	702,038	56,947	593,167	54,155	0	30.00
31.00	03100	INTENSIVE CARE UNIT	27,120	6,010	79,090	2,300	0	31.00
43.00	04300	NURSERY	0	5,096	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	10,814	82,950	208,367	0	50.00
51.00	05100	RECOVERY ROOM	0	4,162	62,644	10,678	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	26,413	15,931	38,628	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	33,745	277	165,474	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	30,489	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	12,448	0	19,769	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,438	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	39	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,481	0	2,073	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	25,042	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	52,565	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,116,074	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	3,349	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,139	27,319	2,529	0	90.00
91.00	09100	EMERGENCY	0	27,327	302,056	55,501	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	48,741	1,543	49,480	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	729,158	274,045	1,164,977	738,075	1,116,074	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	729,158	274,045	1,164,977	738,075	1,116,074	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 10:49 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	689,110					16.00
17.00	01700	SOCIAL SERVICE	0	398,788				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	592,635	329,978	9,391,491	0	9,391,491	30.00
31.00	03100	INTENSIVE CARE UNIT	27,564	27,628	1,054,615	0	1,054,615	31.00
43.00	04300	NURSERY	0	41,182	623,899	0	623,899	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	55,129	0	3,131,859	0	3,131,859	50.00
51.00	05100	RECOVERY ROOM	0	0	616,146	0	616,146	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,355,212	0	3,355,212	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	3,245,208	0	3,245,208	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	126,209	0	126,209	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,215,039	0	1,215,039	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,318,125	0	1,318,125	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	345,385	0	345,385	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	124,130	0	124,130	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	709,004	0	709,004	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	154,799	0	154,799	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	200,753	0	200,753	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,402,426	0	2,402,426	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	562,770	0	562,770	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	466,438	0	466,438	90.00
91.00	09100	EMERGENCY	13,782	0	9,370,802	0	9,370,802	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	1,148,181	0	1,148,181	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	689,110	398,788	39,562,491	0	39,562,491	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	73,744	0	73,744	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	603,326	0	603,326	192.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	689,110	398,788	40,239,561	0	40,239,561	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/31/2024 10:49 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,712	12,046	24,758	24,758	4.00
5.01	00570	ADMITTING	0	20,480	19,408	39,888	949	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	0	158,665	150,362	309,027	1,835	5.02
7.00	00700	OPERATION OF PLANT	0	755,433	715,902	1,471,335	632	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	32,918	31,195	64,113	0	8.00
9.00	00900	HOUSEKEEPING	0	31,779	30,116	61,895	637	9.00
10.00	01000	DIETARY	0	40,859	38,721	79,580	308	10.00
11.00	01100	CAFETERIA	0	36,694	34,773	71,467	81	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,089	9,561	19,650	1,046	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	51,250	48,568	99,818	292	14.00
15.00	01500	PHARMACY	0	29,603	28,054	57,657	831	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	47,906	45,399	93,305	66	16.00
17.00	01700	SOCIAL SERVICE	0	12,452	11,801	24,253	318	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	395,098	374,423	769,521	3,975	30.00
31.00	03100	INTENSIVE CARE UNIT	0	49,694	47,093	96,787	532	31.00
43.00	04300	NURSERY	0	10,795	10,230	21,025	453	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	187,115	177,323	364,438	814	50.00
51.00	05100	RECOVERY ROOM	0	14,729	13,959	28,688	379	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	157,685	149,433	307,118	1,687	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	44,260	41,944	86,204	1,614	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,701	1,612	3,313	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	44,721	42,381	87,102	812	65.00
66.00	06600	PHYSICAL THERAPY	0	127,606	120,929	248,535	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,473	3,292	6,765	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	58,586	55,520	114,106	214	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	13,620	12,907	26,527	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	39,173	37,123	76,296	175	90.00
91.00	09100	EMERGENCY	0	106,204	100,646	206,850	6,657	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	36,852	34,924	71,776	451	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,532,152	2,399,645	4,931,797	24,758	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,328	10,735	22,063	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	242,948	230,234	473,182	0	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,786,428	2,640,614	5,427,042	24,758	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/31/2024 10:49 am

		Cost Center Description	ADMITTING	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	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
5.01	00570	ADMITTING	40,837					5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	0	310,862				5.02
7.00	00700	OPERATION OF PLANT	0	41,489	1,513,456			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,934	31,267	97,314		8.00
9.00	00900	HOUSEKEEPING	0	6,732	30,185	0	99,449	9.00
10.00	01000	DIETARY	0	4,362	38,809	0	2,724	10.00
11.00	01100	CAFETERIA	0	976	34,853	0	2,446	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,586	9,583	0	673	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,048	48,679	0	3,416	14.00
15.00	01500	PHARMACY	0	7,505	28,118	0	1,973	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,809	45,503	0	3,194	16.00
17.00	01700	SOCIAL SERVICE	0	2,664	11,828	0	830	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,108	39,961	375,281	80,523	26,337	30.00
31.00	03100	INTENSIVE CARE UNIT	169	5,097	47,201	6,742	3,313	31.00
43.00	04300	NURSERY	35	3,838	10,253	10,049	720	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,104	15,614	177,729	0	12,474	50.00
51.00	05100	RECOVERY ROOM	859	3,703	13,991	0	982	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,957	20,389	149,775	0	10,512	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	5,694	22,152	42,040	0	2,950	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	91	687	1,615	0	113	62.00
65.00	06500	RESPIRATORY THERAPY	852	7,746	42,478	0	2,981	65.00
66.00	06600	PHYSICAL THERAPY	742	6,202	121,206	0	8,507	66.00
67.00	06700	OCCUPATIONAL THERAPY	441	2,560	3,299	0	232	67.00
68.00	06800	SPEECH PATHOLOGY	70	959	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,400	3,612	55,647	0	3,905	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	408	1,002	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	244	1,145	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,791	9,937	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	12	3,985	10,267	0	721	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	18	2,138	37,208	0	2,611	90.00
91.00	09100	EMERGENCY	7,193	66,012	100,877	0	7,080	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,649	7,140	35,004	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,837	305,984	1,502,696	97,314	98,694	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	217	10,760	0	755	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,661	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	40,837	310,862	1,513,456	97,314	99,449	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/31/2024 10:49 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	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-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	125,783					10.00
11.00	01100	CAFETERIA	0	109,823				11.00
13.00	01300	NURSING ADMINISTRATION	0	5,160	44,698			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,079	0	159,332		14.00
15.00	01500	PHARMACY	0	3,780	0	3,434	103,298	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,154	0	63	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,543	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	121,105	22,823	22,758	11,691	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,678	2,408	3,035	497	0	31.00
43.00	04300	NURSERY	0	2,042	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,334	3,183	44,982	0	50.00
51.00	05100	RECOVERY ROOM	0	1,668	2,404	2,305	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,585	611	8,339	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	13,523	11	35,722	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	6,582	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	4,988	0	4,268	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	310	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	8	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,395	0	447	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,406	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,347	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	103,298	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	723	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	857	1,048	546	0	90.00
91.00	09100	EMERGENCY	0	10,951	11,589	11,981	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	19,533	59	10,681	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	125,783	109,823	44,698	159,332	103,298	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	125,783	109,823	44,698	159,332	103,298	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/31/2024 10:49 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	147,094					16.00
17.00	01700	SOCIAL SERVICE	0	41,436				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	126,500	34,286	1,636,869	0	1,636,869	30.00
31.00	03100	INTENSIVE CARE UNIT	5,884	2,871	179,214	0	179,214	31.00
43.00	04300	NURSERY	0	4,279	52,694	0	52,694	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,768	0	639,440	0	639,440	50.00
51.00	05100	RECOVERY ROOM	0	0	54,979	0	54,979	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	517,973	0	517,973	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	209,910	0	209,910	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	12,401	0	12,401	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	151,227	0	151,227	65.00
66.00	06600	PHYSICAL THERAPY	0	0	385,502	0	385,502	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	13,305	0	13,305	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,029	0	1,029	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	180,726	0	180,726	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	6,816	0	6,816	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	12,736	0	12,736	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	118,026	0	118,026	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	42,235	0	42,235	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	120,897	0	120,897	90.00
91.00	09100	EMERGENCY	2,942	0	432,132	0	432,132	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	147,293	0	147,293	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	147,094	41,436	4,915,404	0	4,915,404	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	33,795	0	33,795	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	477,843	0	477,843	192.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	147,094	41,436	5,427,042	0	5,427,042	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 10:49 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (TIME SPENT)	Reconciliation	
			1.00	2.00	4.00	5.01	5A.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	193,337					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		193,337				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	882	882	15,138,334			4.00
5.01	00570	ADMITTING	1,421	1,421	580,409	182,038,506		5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	11,009	11,009	1,122,064	0	-8,680,136	5.02
7.00	00700	OPERATION OF PLANT	52,416	52,416	386,822	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,284	2,284	0	0	0	8.00
9.00	00900	HOUSEKEEPING	2,205	2,205	389,501	0	0	9.00
10.00	01000	DIETARY	2,835	2,835	188,633	0	0	10.00
11.00	01100	CAFETERIA	2,546	2,546	49,301	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	700	700	639,692	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,556	3,556	178,670	0	0	14.00
15.00	01500	PHARMACY	2,054	2,054	508,533	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,324	3,324	40,088	0	0	16.00
17.00	01700	SOCIAL SERVICE	864	864	194,304	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,414	27,414	2,431,416	9,409,324	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,448	3,448	325,684	754,363	0	31.00
43.00	04300	NURSERY	749	749	276,819	156,188	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,983	12,983	497,949	18,319,256	0	50.00
51.00	05100	RECOVERY ROOM	1,022	1,022	231,646	3,837,051	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,941	10,941	1,031,670	39,713,142	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	3,071	3,071	987,381	25,421,618	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	118	118	0	407,431	0	62.00
65.00	06500	RESPIRATORY THERAPY	3,103	3,103	496,397	3,804,553	0	65.00
66.00	06600	PHYSICAL THERAPY	8,854	8,854	0	3,312,908	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	241	241	0	1,967,320	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	310,840	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,065	4,065	130,762	6,251,373	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,822,508	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,087,894	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	21,388,601	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	945	945	0	51,877	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,718	2,718	107,120	82,300	0	90.00
91.00	09100	EMERGENCY	7,369	7,369	4,067,504	32,112,444	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,557	2,557	275,969	11,827,515	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	175,694	175,694	15,138,334	182,038,506	-8,680,136	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	786	786	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,857	16,857	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,786,428	2,640,614	2,796,943	1,588,347		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.412285	13.658089	0.184759	0.008725		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			24,758	40,837		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001635	0.000224		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 10:49 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL (ACCUMULATE D COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATI ENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DA YS)	
			5.02	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	31,559,425					5.02
7.00	00700	OPERATION OF PLANT	4,212,063	110,557				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	196,347	2,284	2,295			8.00
9.00	00900	HOUSEKEEPING	683,487	2,205	0	103,511		9.00
10.00	01000	DIETARY	442,841	2,835	0	2,835	2,124	10.00
11.00	01100	CAFETERIA	99,053	2,546	0	2,546	0	11.00
13.00	01300	NURSING ADMINISTRATION	871,720	700	0	700	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	410,993	3,556	0	3,556	0	14.00
15.00	01500	PHARMACY	761,965	2,054	0	2,054	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	386,689	3,324	0	3,324	0	16.00
17.00	01700	SOCIAL SERVICE	270,421	864	0	864	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,056,926	27,414	1,899	27,414	2,045	30.00
31.00	03100	INTENSIVE CARE UNIT	517,459	3,448	159	3,448	79	31.00
43.00	04300	NURSERY	389,670	749	237	749	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,585,188	12,983	0	12,983	0	50.00
51.00	05100	RECOVERY ROOM	375,952	1,022	0	1,022	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,069,989	10,941	0	10,941	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,248,946	3,071	0	3,071	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	69,701	118	0	118	0	62.00
65.00	06500	RESPIRATORY THERAPY	786,446	3,103	0	3,103	0	65.00
66.00	06600	PHYSICAL THERAPY	629,689	8,854	0	8,854	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	259,883	241	0	241	0	67.00
68.00	06800	SPEECH PATHOLOGY	97,354	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	366,697	4,065	0	4,065	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	101,767	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	116,222	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,008,871	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	404,613	750	0	750	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	217,030	2,718	0	2,718	0	90.00
91.00	09100	EMERGENCY	6,701,355	7,369	0	7,369	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	724,843	2,557	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,064,180	109,771	2,295	102,725	2,124	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	22,063	786	0	786	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	473,182	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	8,680,136	5,370,553	361,300	978,587	729,158	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.275041	48.577232	157.429194	9.453942	343.294727	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	310,862	1,513,456	97,314	99,449	125,783	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.009850	13.689373	42.402614	0.960758	59.219868	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 10:49 am

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQ)	PHARMACY (COSTED REQ)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	14,090					11.00
13.00	01300	NURSING ADMINISTRATION	662	4,190,723				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	395	0	1,521,071			14.00
15.00	01500	PHARMACY	485	0	32,784	822,255		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	148	0	600	0	100	16.00
17.00	01700	SOCIAL SERVICE	198	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,928	2,133,779	111,605	0	86	30.00
31.00	03100	INTENSIVE CARE UNIT	309	284,506	4,740	0	4	31.00
43.00	04300	NURSERY	262	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	556	298,393	429,421	0	8	50.00
51.00	05100	RECOVERY ROOM	214	225,346	22,006	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,358	57,309	79,606	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,735	997	341,018	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62,833	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	640	0	40,741	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,964	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	80	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	179	0	4,272	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	51,609	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	108,329	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	822,255	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	6,901	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	110	98,273	5,211	0	0	90.00
91.00	09100	EMERGENCY	1,405	1,086,570	114,380	0	2	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,506	5,550	101,971	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,090	4,190,723	1,521,071	822,255	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	274,045	1,164,977	738,075	1,116,074	689,110	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.449610	0.277990	0.485234	1.357333	6,891.100000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	109,823	44,698	159,332	103,298	147,094	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.794393	0.010666	0.104750	0.125628	1,470.940000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 10:49 am

		Cost Center Description	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			17.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00570	ADMITTING		5.01
5.02	00590	ADMINISTRATIVE AND GENERAL		5.02
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	2,295	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	1,899	30.00
31.00	03100	INTENSIVE CARE UNIT	159	31.00
43.00	04300	NURSERY	237	43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
54.01	05401	ULTRASOUND	0	54.01
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
60.00	06000	LABORATORY	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03610	SLEEP LAB	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	76.02
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0	95.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,295	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	398,788	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	173.763834	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	41,436	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	18.054902	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 10:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,391,491		9,391,491	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,054,615		1,054,615	0	0	31.00
43.00	04300	NURSERY	623,899		623,899	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,131,859		3,131,859	0	0	50.00
51.00	05100	RECOVERY ROOM	616,146		616,146	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,355,212		3,355,212	0	0	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	3,245,208		3,245,208	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	126,209		126,209	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,215,039	0	1,215,039	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,318,125	0	1,318,125	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	345,385	0	345,385	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	124,130	0	124,130	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	709,004		709,004	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	154,799		154,799	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	200,753		200,753	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,402,426		2,402,426	0	0	73.00
76.00	03610	SLEEP LAB	0		0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0		0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	562,770		562,770	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	466,438		466,438	0	0	90.00
91.00	09100	EMERGENCY	9,370,802		9,370,802	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,545,830		1,545,830		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,148,181		1,148,181	0	0	95.00
200.00		Subtotal (see instructions)	41,108,321	0	41,108,321	0	0	200.00
201.00		Less Observation Beds	1,545,830		1,545,830		0	201.00
202.00		Total (see instructions)	39,562,491	0	39,562,491	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 10:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,419,173		7,419,173			30.00
31.00	03100	INTENSIVE CARE UNIT	754,363		754,363			31.00
43.00	04300	NURSERY	156,188		156,188			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,603,237	15,716,019	18,319,256	0.170960	0.000000	50.00
51.00	05100	RECOVERY ROOM	422,322	3,414,729	3,837,051	0.160578	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,170,409	34,542,733	39,713,142	0.084486	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	4,844,646	20,576,972	25,421,618	0.127655	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	212,479	194,952	407,431	0.309768	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	3,010,976	793,577	3,804,553	0.319364	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,198,304	2,114,604	3,312,908	0.397876	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,265,810	701,510	1,967,320	0.175561	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	110,781	200,059	310,840	0.399337	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,343,107	4,908,266	6,251,373	0.113416	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,155,476	667,032	1,822,508	0.084937	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	237,669	850,225	1,087,894	0.184534	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,553,841	11,834,760	21,388,601	0.112323	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0.000000	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	51,877	51,877	10.848160	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	22,130	60,170	82,300	5.667533	0.000000	90.00
91.00	09100	EMERGENCY	2,985,468	29,126,976	32,112,444	0.291812	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	670,698	1,319,453	1,990,151	0.776740	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	12,088	11,815,427	11,827,515	0.097077	0.000000	95.00
200.00		Subtotal (see instructions)	43,149,165	138,889,341	182,038,506			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	43,149,165	138,889,341	182,038,506			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 10:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03610	SLEEP LAB	0.000000		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
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: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 10:49 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,391,491		9,391,491	0	9,391,491	30.00
31.00	03100	INTENSIVE CARE UNIT	1,054,615		1,054,615	0	1,054,615	31.00
43.00	04300	NURSERY	623,899		623,899	0	623,899	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,131,859		3,131,859	0	3,131,859	50.00
51.00	05100	RECOVERY ROOM	616,146		616,146	0	616,146	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,355,212		3,355,212	0	3,355,212	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	3,245,208		3,245,208	0	3,245,208	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	126,209		126,209	0	126,209	62.00
65.00	06500	RESPIRATORY THERAPY	1,215,039	0	1,215,039	0	1,215,039	65.00
66.00	06600	PHYSICAL THERAPY	1,318,125	0	1,318,125	0	1,318,125	66.00
67.00	06700	OCCUPATIONAL THERAPY	345,385	0	345,385	0	345,385	67.00
68.00	06800	SPEECH PATHOLOGY	124,130	0	124,130	0	124,130	68.00
69.00	06900	ELECTROCARDIOLOGY	709,004		709,004	0	709,004	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	154,799		154,799	0	154,799	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	200,753		200,753	0	200,753	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,402,426		2,402,426	0	2,402,426	73.00
76.00	03610	SLEEP LAB	0		0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0		0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	562,770		562,770	0	562,770	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	466,438		466,438	0	466,438	90.00
91.00	09100	EMERGENCY	9,370,802		9,370,802	0	9,370,802	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,545,830		1,545,830		1,545,830	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,148,181		1,148,181	0	1,148,181	95.00
200.00		Subtotal (see instructions)	41,108,321	0	41,108,321	0	41,108,321	200.00
201.00		Less Observation Beds	1,545,830		1,545,830		1,545,830	201.00
202.00		Total (see instructions)	39,562,491	0	39,562,491	0	39,562,491	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 10:49 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,419,173		7,419,173			30.00
31.00	03100	INTENSIVE CARE UNIT	754,363		754,363			31.00
43.00	04300	NURSERY	156,188		156,188			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,603,237	15,716,019	18,319,256	0.170960	0.000000	50.00
51.00	05100	RECOVERY ROOM	422,322	3,414,729	3,837,051	0.160578	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,170,409	34,542,733	39,713,142	0.084486	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	4,844,646	20,576,972	25,421,618	0.127655	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	212,479	194,952	407,431	0.309768	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	3,010,976	793,577	3,804,553	0.319364	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,198,304	2,114,604	3,312,908	0.397876	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,265,810	701,510	1,967,320	0.175561	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	110,781	200,059	310,840	0.399337	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,343,107	4,908,266	6,251,373	0.113416	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,155,476	667,032	1,822,508	0.084937	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	237,669	850,225	1,087,894	0.184534	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,553,841	11,834,760	21,388,601	0.112323	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0.000000	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	51,877	51,877	10.848160	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	22,130	60,170	82,300	5.667533	0.000000	90.00
91.00	09100	EMERGENCY	2,985,468	29,126,976	32,112,444	0.291812	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	670,698	1,319,453	1,990,151	0.776740	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	12,088	11,815,427	11,827,515	0.097077	0.000000	95.00
200.00		Subtotal (see instructions)	43,149,165	138,889,341	182,038,506			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	43,149,165	138,889,341	182,038,506			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 10:49 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.170960	50.00
51.00	05100	RECOVERY ROOM	0.160578	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084486	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.127655	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.309768	62.00
65.00	06500	RESPIRATORY THERAPY	0.319364	65.00
66.00	06600	PHYSICAL THERAPY	0.397876	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.175561	67.00
68.00	06800	SPEECH PATHOLOGY	0.399337	68.00
69.00	06900	ELECTROCARDIOLOGY	0.113416	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.084937	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.184534	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.112323	73.00
76.00	03610	SLEEP LAB	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	10.848160	76.02
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	5.667533	90.00
91.00	09100	EMERGENCY	0.291812	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.776740	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.097077	95.00
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 MEDICAID ONLY

Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/31/2024 10:49 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,131,859	639,440	2,492,419	0	0	50.00
51.00	05100	RECOVERY ROOM	616,146	54,979	561,167	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,355,212	517,973	2,837,239	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	3,245,208	209,910	3,035,298	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	126,209	12,401	113,808	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,215,039	151,227	1,063,812	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,318,125	385,502	932,623	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	345,385	13,305	332,080	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	124,130	1,029	123,101	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	709,004	180,726	528,278	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	154,799	6,816	147,983	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	200,753	12,736	188,017	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,402,426	118,026	2,284,400	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	562,770	42,235	520,535	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	466,438	120,897	345,541	0	0	90.00
91.00	09100	EMERGENCY	9,370,802	432,132	8,938,670	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,545,830	269,427	1,276,403	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,148,181	147,293	1,000,888	0	0	95.00
200.00		Subtotal (sum of lines 50 thru 199)	30,038,316	3,316,054	26,722,262	0	0	200.00
201.00		Less Observation Beds	1,545,830	269,427	1,276,403	0	0	201.00
202.00		Total (line 200 minus line 201)	28,492,486	3,046,627	25,445,859	0	0	202.00

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

Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II Date/Time Prepared: 5/31/2024 10:49 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,131,859	18,319,256	0.170960		50.00
51.00	05100	RECOVERY ROOM	616,146	3,837,051	0.160578		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,355,212	39,713,142	0.084486		54.00
54.01	05401	ULTRASOUND	0	0	0.000000		54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MRI	0	0	0.000000		58.00
60.00	06000	LABORATORY	3,245,208	25,421,618	0.127655		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	126,209	407,431	0.309768		62.00
65.00	06500	RESPIRATORY THERAPY	1,215,039	3,804,553	0.319364		65.00
66.00	06600	PHYSICAL THERAPY	1,318,125	3,312,908	0.397876		66.00
67.00	06700	OCCUPATIONAL THERAPY	345,385	1,967,320	0.175561		67.00
68.00	06800	SPEECH PATHOLOGY	124,130	310,840	0.399337		68.00
69.00	06900	ELECTROCARDIOLOGY	709,004	6,251,373	0.113416		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	154,799	1,822,508	0.084937		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	200,753	1,087,894	0.184534		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,402,426	21,388,601	0.112323		73.00
76.00	03610	SLEEP LAB	0	0	0.000000		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0.000000		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	562,770	51,877	10.848160		76.02
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	466,438	82,300	5.667533		90.00
91.00	09100	EMERGENCY	9,370,802	32,112,444	0.291812		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,545,830	1,990,151	0.776740		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,148,181	11,827,515	0.097077		95.00
200.00		Subtotal (sum of lines 50 thru 199)	30,038,316	173,708,782			200.00
201.00		Less Observation Beds	1,545,830	0			201.00
202.00		Total (line 200 minus line 201)	28,492,486	173,708,782			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/31/2024 10:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	639,440	18,319,256	0.034905	255,268	8,910	50.00
51.00	05100	RECOVERY ROOM	54,979	3,837,051	0.014328	47,175	676	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	517,973	39,713,142	0.013043	1,672,988	21,821	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	209,910	25,421,618	0.008257	1,455,413	12,017	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	12,401	407,431	0.030437	81,871	2,492	62.00
65.00	06500	RESPIRATORY THERAPY	151,227	3,804,553	0.039749	915,771	36,401	65.00
66.00	06600	PHYSICAL THERAPY	385,502	3,312,908	0.116364	277,513	32,293	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,305	1,967,320	0.006763	279,874	1,893	67.00
68.00	06800	SPEECH PATHOLOGY	1,029	310,840	0.003310	38,815	128	68.00
69.00	06900	ELECTROCARDIOLOGY	180,726	6,251,373	0.028910	540,866	15,636	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,816	1,822,508	0.003740	359,407	1,344	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,736	1,087,894	0.011707	79,347	929	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	118,026	21,388,601	0.005518	2,917,803	16,100	73.00
76.00	03610	SLEEP LAB	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	42,235	51,877	0.814137	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	120,897	82,300	1.468979	0	0	90.00
91.00	09100	EMERGENCY	432,132	32,112,444	0.013457	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	269,427	1,990,151	0.135380	1,185	160	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	3,168,761	161,881,267		8,923,296	150,800	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/31/2024 10:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/31/2024 10:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	18,319,256	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,837,051	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	39,713,142	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	25,421,618	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	407,431	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,804,553	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,312,908	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,967,320	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	310,840	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,251,373	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,822,508	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,087,894	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	21,388,601	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	51,877	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	82,300	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	32,112,444	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,990,151	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	161,881,267		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/31/2024 10:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	255,268	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	47,175	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,672,988	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,455,413	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	81,871	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	915,771	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	277,513	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	279,874	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	38,815	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	540,866	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	359,407	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	79,347	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,917,803	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,185	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		8,923,296	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 10:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.170960	0	2,909,843	0	0	50.00
51.00	05100	RECOVERY ROOM	0.160578	0	702,295	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084486	0	7,438,547	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.127655	0	4,093,113	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.309768	0	65,056	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.319364	0	211,382	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.397876	0	372,122	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.175561	0	63,485	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.399337	0	11,557	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.113416	0	1,422,555	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.084937	0	82,032	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.184534	0	136,385	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.112323	0	4,225,952	1,674	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	10.848160	0	38,675	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5.667533	0	10,335	292	0	90.00
91.00	09100	EMERGENCY	0.291812	0	4,963,365	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.776740	0	460,837	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.097077		0			95.00
200.00		Subtotal (see instructions)		0	27,207,536	1,966	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	27,207,536	1,966	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 10:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	497,467	0	50.00
51.00	05100	RECOVERY ROOM	112,773	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	628,453	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	522,506	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	20,152	0	62.00
65.00	06500	RESPIRATORY THERAPY	67,508	0	65.00
66.00	06600	PHYSICAL THERAPY	148,058	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,145	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,615	0	68.00
69.00	06900	ELECTROCARDIOLOGY	161,340	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,968	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,168	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	474,672	188	73.00
76.00	03610	SLEEP LAB	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	419,553	0	76.02
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	58,574	1,655	90.00
91.00	09100	EMERGENCY	1,448,369	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	357,951	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	4,965,272	1,843	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	4,965,272	1,843	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/31/2024 10:49 am

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	1,636,869	510,422	1,126,447	2,496	451.30	30.00
31.00	INTENSIVE CARE UNIT	179,214		179,214	159	1,127.13	31.00
43.00	NURSERY	52,694		52,694	237	222.34	43.00
200.00	Total (lines 30 through 199)	1,868,777		1,358,355	2,892		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	71	32,042		30.00
31.00	INTENSIVE CARE UNIT	6	6,763		31.00
43.00	NURSERY	16	3,557		43.00
200.00	Total (lines 30 through 199)	93	42,362		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/31/2024 10:49 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	639,440	18,319,256	0.034905	251,437	8,776	50.00
51.00	05100	RECOVERY ROOM	54,979	3,837,051	0.014328	38,694	554	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	517,973	39,713,142	0.013043	178,721	2,331	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	209,910	25,421,618	0.008257	166,838	1,378	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	12,401	407,431	0.030437	17,394	529	62.00
65.00	06500	RESPIRATORY THERAPY	151,227	3,804,553	0.039749	50,789	2,019	65.00
66.00	06600	PHYSICAL THERAPY	385,502	3,312,908	0.116364	5,050	588	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,305	1,967,320	0.006763	7,880	53	67.00
68.00	06800	SPEECH PATHOLOGY	1,029	310,840	0.003310	3,724	12	68.00
69.00	06900	ELECTROCARDIOLOGY	180,726	6,251,373	0.028910	23,004	665	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,816	1,822,508	0.003740	31,716	119	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,736	1,087,894	0.011707	3,284	38	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	118,026	21,388,601	0.005518	282,649	1,560	73.00
76.00	03610	SLEEP LAB	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	42,235	51,877	0.814137	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	120,897	82,300	1.468979	1,864	2,738	90.00
91.00	09100	EMERGENCY	432,132	32,112,444	0.013457	98,893	1,331	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	269,427	1,990,151	0.135380	14,094	1,908	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	3,168,761	161,881,267		1,176,031	24,599	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/31/2024 10:49 am

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,496	0.00	71	30.00
31.00	03100	INTENSIVE CARE UNIT		0	159	0.00	6	31.00
43.00	04300	NURSERY		0	237	0.00	16	43.00
200.00		Total (lines 30 through 199)		0	2,892		93	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/31/2024 10:49 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/31/2024 10:49 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	18,319,256	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,837,051	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	39,713,142	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	25,421,618	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	407,431	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,804,553	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,312,908	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,967,320	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	310,840	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,251,373	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,822,508	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,087,894	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	21,388,601	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	51,877	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	82,300	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	32,112,444	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,990,151	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	161,881,267		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/31/2024 10:49 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	251,437	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	38,694	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	178,721	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	166,838	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	17,394	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	50,789	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	5,050	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	7,880	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	3,724	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	23,004	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	31,716	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,284	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	282,649	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	1,864	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	98,893	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	14,094	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,176,031	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 10:49 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.170960	0	329,555	0	0	50.00
51.00	05100	RECOVERY ROOM	0.160578	0	52,370	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084486	0	574,377	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.127655	0	357,416	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.309768	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.319364	0	7,112	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.397876	0	102,604	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.175561	0	95,101	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.399337	0	10,604	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.113416	0	59,339	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.084937	0	17,397	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.184534	0	93,126	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.112323	0	162,873	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	10.848160	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5.667533	0	1,094	0	0	90.00
91.00	09100	EMERGENCY	0.291812	0	766,628	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.776740	0	46,614	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.097077	0	318,051			95.00
200.00		Subtotal (see instructions)		0	2,994,261	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	2,994,261	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 10:49 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	56,341	0		50.00
51.00	05100	RECOVERY ROOM	8,409	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,527	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	45,626	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	2,271	0		65.00
66.00	06600	PHYSICAL THERAPY	40,824	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	16,696	0		67.00
68.00	06800	SPEECH PATHOLOGY	4,235	0		68.00
69.00	06900	ELECTROCARDIOLOGY	6,730	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,478	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,185	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,294	0		73.00
76.00	03610	SLEEP LAB	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	6,200	0		90.00
91.00	09100	EMERGENCY	223,711	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	36,207	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	30,875			95.00
200.00		Subtotal (see instructions)	563,609	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	563,609	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 10:49 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,628	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,496	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)	1,899	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,131	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	1	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)	833	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)	755	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	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)	9,391,491	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)	2,928,532	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,462,959	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)	6,462,959	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,589.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,156,912	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)	2,156,912	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 10:49 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,054,615	159	6,632.80	64	424,499	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)	1,306,395	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)	3,887,806	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	1,954,944	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	1,954,944	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)	597	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,589.33	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,545,830	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 10:49 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,636,869	9,391,491	0.174293	1,545,830	269,427	90.00
91.00	Nursing Program cost	0	9,391,491	0.000000	1,545,830	0	91.00
92.00	Allied health cost	0	9,391,491	0.000000	1,545,830	0	92.00
93.00	All other Medical Education	0	9,391,491	0.000000	1,545,830	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 10:49 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,628	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,496	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)	1,899	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,131	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	1	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)	71	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)	237	15.00
16.00	Nursery days (title V or XIX only)	16	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	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)	9,391,491	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)	2,928,532	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,462,959	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)	6,462,959	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,589.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	183,842	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)	183,842	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 10:49 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	623,899	237	2,632.49	16	42,120	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,054,615	159	6,632.80	6	39,797	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)	200,109	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)	465,868	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)	42,362	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	24,599	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	66,961	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	398,907	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)	597	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,589.33	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,545,830	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 10:49 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,636,869	9,391,491	0.174293	1,545,830	269,427	90.00
91.00	Nursing Program cost	0	9,391,491	0.000000	1,545,830	0	91.00
92.00	Allied health cost	0	9,391,491	0.000000	1,545,830	0	92.00
93.00	All other Medical Education	0	9,391,491	0.000000	1,545,830	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/31/2024 10:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,332,689		30.00
31.00	03100	INTENSIVE CARE UNIT		260,546		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.170960	255,268	43,641	50.00
51.00	05100	RECOVERY ROOM	0.160578	47,175	7,575	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084486	1,672,988	141,344	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.127655	1,455,413	185,791	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.309768	81,871	25,361	62.00
65.00	06500	RESPIRATORY THERAPY	0.319364	915,771	292,464	65.00
66.00	06600	PHYSICAL THERAPY	0.397876	277,513	110,416	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.175561	279,874	49,135	67.00
68.00	06800	SPEECH PATHOLOGY	0.399337	38,815	15,500	68.00
69.00	06900	ELECTROCARDIOLOGY	0.113416	540,866	61,343	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.084937	359,407	30,527	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.184534	79,347	14,642	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.112323	2,917,803	327,736	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	10.848160	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	5.667533	0	0	90.00
91.00	09100	EMERGENCY	0.291812	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.776740	1,185	920	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		8,923,296	1,306,395	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)		8,923,296		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3

Component CCN: 15-Z318 | Date/Time Prepared: 5/31/2024 10:49 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.170960	1,770	303	50.00
51.00	05100	RECOVERY ROOM	0.160578	2,805	450	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084486	55,288	4,671	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.127655	319,506	40,787	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.309768	8,757	2,713	62.00
65.00	06500	RESPIRATORY THERAPY	0.319364	688,504	219,883	65.00
66.00	06600	PHYSICAL THERAPY	0.397876	394,723	157,051	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.175561	471,656	82,804	67.00
68.00	06800	SPEECH PATHOLOGY	0.399337	24,941	9,960	68.00
69.00	06900	ELECTROCARDIOLOGY	0.113416	5,384	611	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.084937	203,074	17,248	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.184534	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.112323	925,754	103,983	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	10.848160	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	5.667533	0	0	90.00
91.00	09100	EMERGENCY	0.291812	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.776740	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,102,162	640,464	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)		3,102,162		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/31/2024 10:49 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		172,629		30.00
31.00	03100	INTENSIVE CARE UNIT		44,569		31.00
43.00	04300	NURSERY		16,499		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.170960	251,437	42,986	50.00
51.00	05100	RECOVERY ROOM	0.160578	38,694	6,213	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084486	178,721	15,099	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.127655	166,838	21,298	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.309768	17,394	5,388	62.00
65.00	06500	RESPIRATORY THERAPY	0.319364	50,789	16,220	65.00
66.00	06600	PHYSICAL THERAPY	0.397876	5,050	2,009	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.175561	7,880	1,383	67.00
68.00	06800	SPEECH PATHOLOGY	0.399337	3,724	1,487	68.00
69.00	06900	ELECTROCARDIOLOGY	0.113416	23,004	2,609	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.084937	31,716	2,694	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.184534	3,284	606	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.112323	282,649	31,748	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	10.848160	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	5.667533	1,864	10,564	90.00
91.00	09100	EMERGENCY	0.291812	98,893	28,858	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.776740	14,094	10,947	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,176,031	200,109	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,176,031		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part B Date/Time Prepared: 5/31/2024 10:49 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,967,115	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	5,441,892	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,967,115	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	5,016,786	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	5,441,892	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	36,111	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,548,859	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	431,816	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	431,816	30.00
31.00	Primary payer payments	189	31.00
32.00	Subtotal (line 30 minus line 31)	431,627	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	420,824	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	273,536	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	416,272	36.00
37.00	Subtotal (see instructions)	705,163	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	705,163	40.00
40.01	Sequestration adjustment (see instructions)	14,103	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	839,064	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-148,004	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1318	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/31/2024 10:49 am
	Title XVIII	Hospital	Cost

			1.00	
94.00	Total (sum of lines 91 and 93)		0	94.00
			1.00	
	MEDICARE PART B ANCILLARY COSTS			
200.00	Part B Combined Billed Days		0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2024 10:49 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,587,037		839,064	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/04/2023	228,200		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		228,200		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,815,237		839,064	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		752,249		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		148,004	6.02
7.00	Total Medicare program liability (see instructions)		3,567,486		691,060	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1318 | Component CCN: 15-Z318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2024 10:49 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,805,581		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/04/2023	213,700		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		213,700		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,019,281		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		541,280		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,560,561		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1318	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/31/2024 10:49 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1318 | Component CCN: 15-Z318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/31/2024 10:49 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,974,493	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	646,869	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	755	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,621,362	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,621,362	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	2,621,362	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	8,545	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	2,612,817	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	2,612,817	0	19.00
19.01	Sequestration adjustment (see instructions)	52,256	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	2,019,281	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	541,280	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1318	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/31/2024 10:49 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,887,806	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	3,887,806	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,926,684	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,926,684	19.00
20.00	Deductibles (exclude professional component)	302,224	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,624,460	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,624,460	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	24,357	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	15,832	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	22,228	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,640,292	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	3,640,292	30.00
30.01	Sequestration adjustment (see instructions)	72,806	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2,815,237	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	752,249	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-3 Part VII Date/Time Prepared: 5/31/2024 10:49 am

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		563,609	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	563,609	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	563,609	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	233,696		8.00
9.00	Ancillary service charges	1,176,031	2,994,261	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,409,727	2,994,261	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,409,727	2,994,261	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,409,727	2,430,652	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	563,609	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	563,609	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	563,609	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	563,609	36.00
37.00	REMOVE SETTLEMENT	0	-563,609	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/31/2024 10:49 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-439,030	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	10,127,050	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,806,380	0	0	0	6.00
7.00	Inventory	931,193	0	0	0	7.00
8.00	Prepaid expenses	499,197	0	0	0	8.00
9.00	Other current assets	32,325	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	9,344,355	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	500,000	0	0	0	12.00
13.00	Land improvements	246,545	0	0	0	13.00
14.00	Accumulated depreciation	-167,935	0	0	0	14.00
15.00	Buildings	10,619,283	0	0	0	15.00
16.00	Accumulated depreciation	-5,148,855	0	0	0	16.00
17.00	Leasehold improvements	11,476,985	0	0	0	17.00
18.00	Accumulated depreciation	-6,794,231	0	0	0	18.00
19.00	Fixed equipment	3,112,251	0	0	0	19.00
20.00	Accumulated depreciation	-2,239,778	0	0	0	20.00
21.00	Automobiles and trucks	609,143	0	0	0	21.00
22.00	Accumulated depreciation	-583,590	0	0	0	22.00
23.00	Major movable equipment	8,657,506	0	0	0	23.00
24.00	Accumulated depreciation	-5,787,935	0	0	0	24.00
25.00	Minor equipment depreciable	4,385,337	0	0	0	25.00
26.00	Accumulated depreciation	-3,554,461	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	15,330,265	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,610,606	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,610,606	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	28,285,226	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	991,218	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,490,126	0	0	0	38.00
39.00	Payroll taxes payable	128,296	0	0	0	39.00
40.00	Notes and loans payable (short term)	250,516	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-37,313,697	0	0	0	43.00
44.00	Other current liabilities	420,790	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-34,032,751	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	356,891	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	356,891	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-33,675,860	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	61,961,086				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	61,961,086	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	28,285,226	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/31/2024 10:49 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		63,678,449		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,717,366				2.00
3.00	Total (sum of line 1 and line 2)		61,961,083		0		3.00
4.00	WORKSHEET G AND G-1 ADJUSTMENTS	3		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)		3		0		10.00
11.00	Subtotal (line 3 plus line 10)		61,961,086		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)		61,961,086		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	WORKSHEET G AND G-1 ADJUSTMENTS		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: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/31/2024 10:49 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,575,361		7,575,361	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7,575,361		7,575,361	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	754,363		754,363	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	754,363		754,363	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,329,724		8,329,724	17.00
18.00	Ancillary services	31,129,055	96,567,316	127,696,371	18.00
19.00	Outpatient services	3,678,296	30,506,599	34,184,895	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	12,088	11,815,427	11,827,515	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	IP CONTRACTED HOSPICE	42,674	0	42,674	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	43,191,837	138,889,342	182,081,179	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		41,740,002		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		41,740,002		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1318 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 5/31/2024 10:49 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	182,081,179	1.00
2.00	Less contractual allowances and discounts on patients' accounts	142,150,463	2.00
3.00	Net patient revenues (line 1 minus line 2)	39,930,716	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	41,740,002	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,809,286	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	91,920	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	91,920	25.00
26.00	Total (line 5 plus line 25)	-1,717,366	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)	-1,717,366	29.00