

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: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet 5 Parts I-III Date/Time Prepared: 4/30/2024 1:27 pm
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PART I - COST REPORT STATUS Date: 4/30/2024 Time: 1:27 pm

Provider use only

1. Electronically prepared cost report
 2. Manually prepared cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

5. 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. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN

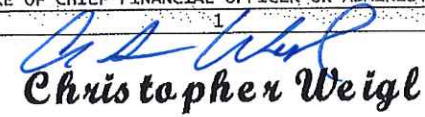
10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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 SSH - EVANSVILLE, LLC. (15-2014) 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  Christopher Weigl	2 Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2 Signatory Printed Name	Christopher Weigl		2
3 Signatory Title	SENIOR VICE PRESIDENT		3
4 Date	04/30/2024 10:34:35 AM (PT)		4

Encryption Information
 ECR: Date: 4/30/2024 Time: 1:27 pm
 E:3KGUWSDNEU:4Zamtxx0Qeyx:Pjv0
 7cFyE0ZrZq.bptLZ.TApIAZ2nx79sc
 vo6Y0bt1nE0pInph

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 HOSPITAL	0	-640,852	0	0	0	1.00
2.00 SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00 SUBPROVIDER - IRF	0	0	0	0	0	3.00
5.00 SWING BED - SNF	0	0	0	0	0	5.00
6.00 SWING BED - NF	0	0	0	0	0	6.00
200.00 TOTAL	0	-640,852	0	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 4/30/2024 1:27 pm
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1.00 Hospital and Hospital Health Care Complex Address:	2.00 PO Box:	3.00 Zip Code: 47713	4.00 County: VANDERBURGH	1.00
2.00 Street: 400 SE 4TH STREET	State: IN	Zip Code: 47713	County: VANDERBURGH	2.00
2.00 City: EVANSVILLE	State: IN	Zip Code: 47713	County: VANDERBURGH	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	SSH - EVANSVILLE, LLC.	152014	21780	2	01/01/1997	N	P	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									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 - FOHC									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	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: 15-2014			Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 4/30/2024 1:27 pm		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0		24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00
						Urban/Rural	S	Date of Geogr	
						1.00		2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00
						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 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

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		V	XVIII	XIX		
		1.00	2.00	3.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N				60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).					61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)					61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)					61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20
						1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 4/30/2024 1:27 pm		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.					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)					
	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)					65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					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)					
	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)					67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 4/30/2024 1:27 pm	
				1.00	
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) 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.				Y 80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N 81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N 85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N 86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.				N 87.00
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
			1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.		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: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 4/30/2024 1:27 pm	
		V 1.00	XIX 2.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. 1, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. 1V, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	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. 1, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. 1 through 1V? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
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 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	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
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			115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 4/30/2024 1:27 pm	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	194,894	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		
119.00	DO NOT USE THIS LINE				
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		
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		
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.		Y	Y	
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		
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.				
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.				
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.				
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.				
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.				
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.				
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.				
133.00	Removed and reserved				
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.				
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	HB0312	
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: NAME: SELECT MEDICAL	Contractor's Name: NOVITAS SOLUTIONS INC.		Contractor's Number: 12001	
142.00	Street: STREET: 4714 GETTYSBURG ROAD	PO Box:			
143.00	City: CITY: MECHANISBURG	State: PA		Zip Code: 17055	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y	
				1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.		Y	N	
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		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-2014			Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 4/30/2024 1:27 pm		
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
		Part A	Part B	Title V	Title XIX				
		1.00	2.00	3.00	4.00				
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital		N	N	N	N		155.00	
156.00	Subprovider - IPF		N	N	N	N		156.00	
157.00	Subprovider - IRF		N	N	N	N		157.00	
158.00	SUBPROVIDER							158.00	
159.00	SNF		N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY		N	N	N	N		160.00	
161.00	CMHC			N	N	N		161.00	
								1.00	
Multi campus									
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	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.							N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								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. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 4/30/2024 1:27 pm	
			Y/N	Date	
			1.00	2.00	
PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE					
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		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
			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)	N		N	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: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 4/30/2024 1:27 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	Y		N	
					21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
					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.	ANDREW		BUTZ	41.00
42.00	Enter the employer/company name of the cost report preparer.	SELECT MEDICAL			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	717-972-1391		APBUTZ@SELECTMEDICAL.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 4/30/2024 1:27 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SR REIMBURSEMENT ANALYST		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: 15-2014

Period:
From 01/01/2023
To 12/31/2023

Worksheet S-3
Part I
Date/Time Prepared:
4/30/2024 1:27 pm

Component	Worksheet A Line No.	No. of Beds	Bed Days Avai lable	CAH/REH Hours	I/P Days / O/P Vi s i t s / Tri ps		
						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	60	21,900	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		60	21,900	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		60	21,900	0.00	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)		60				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: 15-2014

Period:
From 01/01/2023
To 12/31/2023

Worksheet S-3
Part I
Date/Time Prepared:
4/30/2024 1:27 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,013	268	12,618		1.00
2.00	HMO and other (see instructions)	2,517	1,807			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0	0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,013	268	12,618		7.00
8.00	INTENSIVE CARE UNIT					8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY					13.00
14.00	Total (see instructions)	5,013	268	12,618	0.00	143.20
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)			0		24.10
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	143.20
28.00	Observation Bed Days		0	0		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	0	0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	6				33.00
33.01	LTCH site neutral days and discharges	23				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: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part I Date/Time Prepared: 4/30/2024 1:27 pm
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Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	219	14	542	1.00
2.00	HMO and other (see instructions)			108	80		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	219	14	542	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			2			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-2014

Period:
From 01/01/2023
To 12/31/2023

Worksheet S-3
Part II
Date/Time Prepared:
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	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	10,483,483	0	10,483,483	297,850.76	35.20 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		0	33,087	33,087	984.14	33.62 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		3,293,578	0	3,293,578	42,973.52	76.64 11.00
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract Labor: Physician-Part A - Administrative		104,835	0	104,835	690.50	151.82 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		1,176,902	0	1,176,902	23,249.00	50.62 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00 16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.02
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		1,773,082	0	1,773,082		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		5,759	0	5,759		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)	129,034	0	129,034			
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-2014

Period:
From 01/01/2023
To 12/31/2023

Worksheet S-3
Part II
Date/Time Prepared:
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	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)	0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	1,655,507	-33,087	1,622,420	38,265.08	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	406,877	0	406,877	18,365.98	30.00
31.00	Laundry & Linen Service	8.00	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	426,100	0	426,100	22,400.95	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0.00	0.00	33.00
34.00	Dietary	10.00	528,656	0	528,656	22,896.03	34.00
35.00	Dietary under contract (see instructions)		0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	723,181	0	723,181	11,038.46	38.00
39.00	Central Services and Supply	14.00	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	80,161	0	80,161	3,623.80	41.00
42.00	Social Service	17.00	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-2014

Period:
From 01/01/2023
To 12/31/2023

Worksheet S-3
Part III
Date/Time Prepared:
4/30/2024 1:27 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Pai d Hours Related to Sal ari es i n col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	10,483,483	0	10,483,483	297,850.76	35.20	1.00
2.00	Excluded area salaries (see instructions)	0	33,087	33,087	984.14	33.62	2.00
3.00	Subtotal salaries (line 1 minus line 2)	10,483,483	-33,087	10,450,396	296,866.62	35.20	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,575,315	0	4,575,315	66,913.02	68.38	4.00
5.00	Subtotal wage-related costs (see inst.)	1,902,116	0	1,902,116	0.00	18.20	5.00
6.00	Total (sum of lines 3 thru 5)	16,960,914	-33,087	16,927,827	363,779.64	46.53	6.00
7.00	Total overhead cost (see instructions)	3,820,482	-33,087	3,787,395	116,590.30	32.48	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 4/30/2024 1:27 pm
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			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		71,066	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)		717,557	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		12,201	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		25,539	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		143,004	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		761,496	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		27,576	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		14,644	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		1,773,083	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-2014

Period:
From 01/01/2023
To 12/31/2023

Worksheet A

Date/Time Prepared:
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Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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	0	0	965,149	965,149	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,917,396	-2,142,340	775,056	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	450	25,539	25,989	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,655,507	3,150,954	1,101,214	5,907,675	5.00
7.00	00700	OPERATION OF PLANT	406,877	922,014	0	1,328,891	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	172,636	0	172,636	8.00
9.00	00900	HOUSEKEEPING	426,100	133,548	0	559,648	9.00
10.00	01000	DIETARY	528,656	399,236	-211,728	716,164	10.00
11.00	01100	CAFETERIA	0	0	211,728	211,728	11.00
13.00	01300	NURSING ADMINISTRATION	723,181	141,535	0	864,716	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	80,161	21,628	0	101,789	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,160,931	5,644,932	4,588	9,810,451	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	18,282	80,299	-18,621	79,960	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	182,153	65,462	18,621	266,236	54.00
60.00	06000	LABORATORY	0	610,643	0	610,643	60.00
65.00	06500	RESPIRATORY THERAPY	766,039	364,996	-24,833	1,106,202	65.00
66.00	06600	PHYSICAL THERAPY	280,207	38,303	0	318,510	66.00
67.00	06700	OCCUPATIONAL THERAPY	278,140	44,722	0	322,862	67.00
68.00	06800	SPEECH PATHOLOGY	312,195	42,093	0	354,288	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,735	0	9,735	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	110,446	1,462,764	20,245	1,593,455	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	554,608	880,792	0	1,435,400	73.00
74.00	07400	RENAL DIALYSIS	0	376,275	0	376,275	74.00
76.00	03950	WOUND CARE	0	0	0	0	76.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,483,483	17,480,413	-50,438	27,913,458	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	PROVIDER RELATIONS NRCC	0	0	50,438	50,438	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	194.01
194.02	07952	NRCC VACANT SPACE	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	10,483,483	17,480,413	0	27,963,896	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-2014

Period:
From 01/01/2023
To 12/31/2023

Worksheet A
Date/Time Prepared:
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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	-54,680	910,469	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	78,713	853,769	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	25,989	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,035,308	6,942,983	5.00
7.00	00700	OPERATION OF PLANT	0	1,328,891	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	172,636	8.00
9.00	00900	HOUSEKEEPING	0	559,648	9.00
10.00	01000	DIETARY	0	716,164	10.00
11.00	01100	CAFETERIA	-30,777	180,951	11.00
13.00	01300	NURSING ADMINISTRATION	0	864,716	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,549	99,240	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-852,273	8,958,178	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	79,960	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	266,236	54.00
60.00	06000	LABORATORY	0	610,643	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,106,202	65.00
66.00	06600	PHYSICAL THERAPY	0	318,510	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	322,862	67.00
68.00	06800	SPEECH PATHOLOGY	0	354,288	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,735	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,593,455	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,435,400	73.00
74.00	07400	RENAL DIALYSIS	0	376,275	74.00
76.00	03950	WOUND CARE	0	0	76.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	173,742	28,087,200	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	PROVIDER RELATIONS NRCC	0	50,438	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	194.01
194.02	07952	NRCC VACANT SPACE	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	173,742	28,137,638	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - FACILITY RENT						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	965,149	1.00	
	TOTALS		0	965,149		
B - EMPLOYEE BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	25,539	1.00	
	TOTALS		0	25,539		
C - CAPITAL RECONCILIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	248,039	1.00	
	TOTALS		0	248,039		
D - OPERATING PORTION OF INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	929,152	1.00	
	TOTALS		0	929,152		
E - PROVIDER RELATIONS NRCC						
1.00	PROVIDER RELATIONS NRCC	194.00	33,087	17,351	1.00	
	TOTALS		33,087	17,351		
F - OXYGEN TANK RENTAL						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	20,245	1.00	
	TOTALS		0	20,245		
G - SITTING SERVICES						
1.00	ADULTS & PEDIATRICS	30.00	4,588	0	1.00	
	TOTALS		4,588	0		
H - PICC LINE RECLASS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	18,621	1.00	
	TOTALS		0	18,621		
I - DIETARY RECLASS TO CAFETERIA						
1.00	CAFETERIA	11.00	0	211,728	1.00	
	TOTALS		0	211,728		
500.00	Grand Total: Increases		37,675	2,435,824	500.00	

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - FACILITY RENT							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	965,149	10		1.00
	TOTALS		0	965,149			
B - EMPLOYEE BENEFITS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	25,539	0		1.00
	TOTALS		0	25,539			
C - CAPITAL RECONCILIATION							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	248,039	12		1.00
	TOTALS		0	248,039			
D - OPERATING PORTION OF INTEREST							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	929,152	11		1.00
	TOTALS		0	929,152			
E - PROVIDER RELATIONS NRCC							
1.00	ADMINISTRATIVE & GENERAL	5.00	33,087	17,351	0		1.00
	TOTALS		33,087	17,351			
F - OXYGEN TANK RENTAL							
1.00	RESPIRATORY THERAPY	65.00	0	20,245	0		1.00
	TOTALS		0	20,245			
G - SITTER SERVICES							
1.00	RESPIRATORY THERAPY	65.00	4,588	0	0		1.00
	TOTALS		4,588	0			
H - PICC LINE RECLASS							
1.00	OPERATING ROOM	50.00	0	18,621	0		1.00
	TOTALS		0	18,621			
I - DIETARY RECLASS TO CAFETERIA							
1.00	DIETARY	10.00	0	211,728	0		1.00
	TOTALS		0	211,728			
500.00	Grand Total: Decreases		37,675	2,435,824			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-2014

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-7
Part I
Date/Time Prepared:
4/30/2024 1:27 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	70,780	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	2,825,194	239,569	0	239,569	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	8,313,078	0	0	0	216,361	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	11,209,052	239,569	0	239,569	216,361	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	11,209,052	239,569	0	239,569	216,361	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	70,780	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	3,064,763	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	8,096,717	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	11,232,260	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	11,232,260	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-2014

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-7
Part II
Date/Time Prepared:
4/30/2024 1:27 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	731,811	780,728	929,152	248,039	227,666	2.00
3.00	Total (sum of lines 1-2)	731,811	780,728	929,152	248,039	227,666	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	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,917,396				2.00
3.00	Total (sum of lines 1-2)	0	2,917,396				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-2014

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-7
Part III
Date/Time Prepared:
4/30/2024 1:27 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	3,135,543	0	3,135,543	0.279155	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,096,717	0	8,096,717	0.720845	0	2.00
3.00	Total (sum of lines 1-2)	11,232,260	0	11,232,260	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	0	910,469	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	810,524	-184,421	2.00
3.00	Total (sum of lines 1-2)	0	0	0	810,524	726,048	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	910,469	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	227,666	0	853,769	2.00
3.00	Total (sum of lines 1-2)	0	0	227,666	0	1,764,238	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-2014

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-8

Date/Time Prepared:
4/30/2024 1:27 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			3.00	4.00	5.00	
1.00	2.00	3.00	4.00	5.00		
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			OCAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			OCAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-852,273			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	1,084,365			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests		0		0.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts		0		0.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL 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			OCAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			OCAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0	0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			OADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-2014

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-8

Date/Time Prepared:
4/30/2024 1:27 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00
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		0.00	0	32.00
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0	0		0.00	0	33.00
34.00 OTHER PERSONNEL EXPENSE	A	-23,944	0	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00 AHA DUES	A	-1,161	0	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00 MEDICAL RECORDS INCOME	B	-2,549	0	MEDICAL RECORDS & LIBRARY	16.00	0	36.00
37.00 DIETARY CAFETERIA INCOME	B	-29,182	0	CAFETERIA	11.00	0	37.00
39.00 GIFTS	A	-35	0	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00 CAFETERIA VENDING REVENUE	B	-1,595	0	CAFETERIA	11.00	0	40.00
41.00 ADD EXP TO A&G DEPT NOT IN WS A	A	116	0	ADMINISTRATIVE & GENERAL	5.00	0	41.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		173,742					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: 15-2014
 Period: From 01/01/2023 To 12/31/2023
 Worksheet A-8-1
 Date/Time Prepared: 4/30/2024 1:27 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE CAPITAL	78,713	0
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ADMIN	1,830,911	770,579
3.00	1.00	CAP REL COSTS-BLDG & FIXT	SMPV	726,052	780,732
4.00	0.00			0	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,635,676	1,551,311

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

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

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

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

6.00	B	0.00	SELECT MEDICAL	100.00	6.00
7.00		0.00		0.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				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: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Date/Time Prepared: 4/30/2024 1:27 pm
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	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	78,713	9		1.00
2.00	1,060,332	0		2.00
3.00	-54,680	10		3.00
4.00	0	0		4.00
5.00	1,084,365			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	HEALTHCARE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-2014

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-8-2

Date/Time Prepared:
4/30/2024 1:27 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	DR. A	7,040	6,080	960	211,500	6	1.00
2.00	30.00	DR. B	7,200	0	7,200	211,500	103	2.00
3.00	30.00	DR. C	11,781	0	11,781	211,500	63	3.00
4.00	30.00	DR. D	18,881	0	18,881	211,500	108	4.00
5.00	30.00	DR. E	20,400	0	20,400	211,500	120	5.00
6.00	30.00	DR. F	12,113	0	12,113	211,500	81	6.00
7.00	30.00	DR. G	9,500	9,500	0	211,500	0	7.00
8.00	30.00	DR. H	39,600	0	39,600	211,500	6,336	8.00
9.00	30.00	DR. I	165,172	165,172	0	211,500	0	9.00
10.00	30.00	DR. J	141,362	0	141,362	211,500	4,068	10.00
11.00	30.00	DR. K	434,700	125,054	309,646	211,500	2,541	11.00
12.00	30.00	DR. L	105,391	0	105,391	211,500	280	12.00
13.00	30.00	DR. M	570,375	207,147	363,228	211,500	2,980	13.00
14.00	30.00	DR. N	177,075	24,100	152,975	211,500	510	14.00
200.00			1,720,590	537,053	1,183,537		17,196	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	30.00	DR. A	610	31	0	0	0	1.00
2.00	30.00	DR. B	10,473	524	0	0	0	2.00
3.00	30.00	DR. C	6,406	320	0	0	0	3.00
4.00	30.00	DR. D	10,982	549	0	0	0	4.00
5.00	30.00	DR. E	12,202	610	0	0	0	5.00
6.00	30.00	DR. F	8,236	412	0	0	0	6.00
7.00	30.00	DR. G	0	0	0	0	0	7.00
8.00	30.00	DR. H	644,262	32,213	0	0	0	8.00
9.00	30.00	DR. I	0	0	0	0	0	9.00
10.00	30.00	DR. J	413,645	20,682	0	0	0	10.00
11.00	30.00	DR. K	258,376	12,919	0	0	0	11.00
12.00	30.00	DR. L	28,471	1,424	0	0	0	12.00
13.00	30.00	DR. M	303,014	15,151	0	0	0	13.00
14.00	30.00	DR. N	51,858	2,593	0	0	0	14.00
200.00			1,748,535	87,428	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	30.00	DR. A	0	610	350	6,430	1.00
2.00	30.00	DR. B	0	10,473	0	0	2.00
3.00	30.00	DR. C	0	6,406	5,375	5,375	3.00
4.00	30.00	DR. D	0	10,982	7,899	7,899	4.00
5.00	30.00	DR. E	0	12,202	8,198	8,198	5.00
6.00	30.00	DR. F	0	8,236	3,877	3,877	6.00
7.00	30.00	DR. G	0	0	0	9,500	7.00
8.00	30.00	DR. H	0	644,262	0	0	8.00
9.00	30.00	DR. I	0	0	0	165,172	9.00
10.00	30.00	DR. J	0	413,645	0	0	10.00
11.00	30.00	DR. K	0	258,376	51,270	176,324	11.00
12.00	30.00	DR. L	0	28,471	76,920	76,920	12.00
13.00	30.00	DR. M	0	303,014	60,214	267,361	13.00
14.00	30.00	DR. N	0	51,858	101,117	125,217	14.00
200.00			0	1,748,535	315,220	852,273	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-2014

Period:
From 01/01/2023
To 12/31/2023

Worksheet B
Part I
Date/Time Prepared:
4/30/2024 1:27 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	910,469	910,469			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	853,769		853,769		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	25,989	0	0	25,989	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,942,983	579,134	618,592	4,022	8,144,731
7.00 00700	OPERATION OF PLANT	1,328,891	0	0	1,009	1,329,900
8.00 00800	LAUNDRY & LINEN SERVICE	172,636	0	0	0	172,636
9.00 00900	HOUSEKEEPING	559,648	0	0	1,056	560,704
10.00 01000	DIETARY	716,164	39,772	42,482	1,311	799,729
11.00 01100	CAFETERIA	180,951	21,525	22,992	0	225,468
13.00 01300	NURSING ADMINISTRATION	864,716	0	0	1,793	866,509
16.00 01600	MEDICAL RECORDS & LIBRARY	99,240	0	0	199	99,439
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	8,958,178	137,767	147,154	10,324	9,253,423
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	79,960	0	0	45	80,005
54.00 05400	RADIOLOGY-DIAGNOSTIC	266,236	7,115	7,600	452	281,403
60.00 06000	LABORATORY	610,643	1,231	1,315	0	613,189
65.00 06500	RESPIRATORY THERAPY	1,106,202	1,970	2,105	1,888	1,112,165
66.00 06600	PHYSICAL THERAPY	318,510	7,471	7,980	695	334,656
67.00 06700	OCCUPATIONAL THERAPY	322,862	0	0	690	323,552
68.00 06800	SPEECH PATHOLOGY	354,288	0	0	774	355,062
69.00 06900	ELECTROCARDIOLOGY	9,735	0	0	0	9,735
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,593,455	0	0	274	1,593,729
73.00 07300	DRUGS CHARGED TO PATIENTS	1,435,400	2,600	2,777	1,375	1,442,152
74.00 07400	RENAL DIALYSIS	376,275	0	0	0	376,275
76.00 03950	WOUND CARE	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	28,087,200	798,585	852,997	25,907	27,974,462
NONREIMBURSABLE COST CENTERS						
194.00 07950	PROVIDER RELATIONS NRCC	50,438	722	772	82	52,014
194.01 07951	NRCC SUBLEASED SPACE	0	0	0	0	0
194.02 07952	NRCC VACANT SPACE	0	111,162	0	0	111,162
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	28,137,638	910,469	853,769	25,989	28,137,638

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-2014

Period:
From 01/01/2023
To 12/31/2023

Worksheet B
Part I
Date/Time Prepared:
4/30/2024 1:27 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,144,731				5.00
7.00	00700	OPERATION OF PLANT	544,806	1,874,706			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	70,722	0	243,358		8.00
9.00	00900	HOUSEKEEPING	229,697	0	0	790,401	9.00
10.00	01000	DIETARY	327,616	338,648	0	142,779	1,608,772
11.00	01100	CAFETERIA	92,365	183,281	0	77,274	0
13.00	01300	NURSING ADMINISTRATION	354,973	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	40,736	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,790,745	1,173,039	243,358	494,567	1,608,772
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	32,775	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	115,279	60,581	0	25,542	0
60.00	06000	LABORATORY	251,198	10,485	0	4,421	0
65.00	06500	RESPIRATORY THERAPY	455,608	16,776	0	7,073	0
66.00	06600	PHYSICAL THERAPY	137,095	63,610	0	26,819	0
67.00	06700	OCCUPATIONAL THERAPY	132,546	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	145,454	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	3,988	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	652,885	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	590,791	22,135	0	9,333	0
74.00	07400	RENAL DIALYSIS	154,144	0	0	0	0
76.00	03950	WOUND CARE	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,123,423	1,868,555	243,358	787,808	1,608,772
NONREIMBURSABLE COST CENTERS							
194.00	07950	PROVIDER RELATIONS NRCC	21,308	6,151	0	2,593	0
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0
194.02	07952	NRCC VACANT SPACE	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	8,144,731	1,874,706	243,358	790,401	1,608,772

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-2014

Period:
From 01/01/2023
To 12/31/2023

Worksheet B
Part I
Date/Time Prepared:
4/30/2024 1:27 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		11.00	13.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	578,388					11.00
13.00	01300	32,609	1,254,091				13.00
16.00	01600	10,697	0	150,872			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	338,134	1,254,091	42,858	18,198,987	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	199	112,979	0	50.00
54.00	05400	27,958	0	1,841	512,604	0	54.00
60.00	06000	0	0	6,385	885,678	0	60.00
65.00	06500	55,916	0	65,159	1,712,697	0	65.00
66.00	06600	22,584	0	2,810	587,574	0	66.00
67.00	06700	22,532	0	2,236	480,866	0	67.00
68.00	06800	18,449	0	2,873	521,838	0	68.00
69.00	06900	0	0	7,921	21,644	0	69.00
71.00	07100	11,473	0	9,369	2,267,456	0	71.00
73.00	07300	31,886	0	7,488	2,103,785	0	73.00
74.00	07400	0	0	1,733	532,152	0	74.00
76.00	03950	0	0	0	0	0	76.00
SPECIAL PURPOSE COST CENTERS							
118.00		572,238	1,254,091	150,872	27,938,260	0	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	6,150	0	0	88,216	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	111,162	0	194.02
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		578,388	1,254,091	150,872	28,137,638	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Prepared: 4/30/2024 1:27 pm
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03950	WOUND CARE	76.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950	PROVIDER RELATIONS NRCC	194.00
194.01	07951	NRCC SUBLEASED SPACE	194.01
194.02	07952	NRCC VACANT SPACE	194.02
200.00	Cross Foot Adjustments		200.00
201.00	Negative Cost Centers		201.00
202.00	TOTAL (sum lines 118 through 201)		202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 4/30/2024 1:27 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	168	579,134	618,592	5.00
7.00	00700	OPERATION OF PLANT	992	0	992	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	9.00
10.00	01000	DIETARY	0	39,772	42,482	10.00
11.00	01100	CAFETERIA	0	21,525	22,992	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	137,767	147,154	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,115	7,600	54.00
60.00	06000	LABORATORY	0	1,231	1,315	60.00
65.00	06500	RESPIRATORY THERAPY	20,245	1,970	2,105	65.00
66.00	06600	PHYSICAL THERAPY	0	7,471	7,980	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	277,927	0	277,927	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,600	2,777	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03950	WOUND CARE	0	0	0	76.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	299,332	798,585	852,997	118.00
NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	0	722	772	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	194.01
194.02	07952	NRCC VACANT SPACE	0	111,162	0	194.02
200.00		Cross Foot Adjustments			0	200.00
201.00		Negative Cost Centers		0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	299,332	910,469	853,769	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 4/30/2024 1:27 pm
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,197,894				5.00
7.00	00700	OPERATION OF PLANT	80,128	81,120			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,401	0	10,401		8.00
9.00	00900	HOUSEKEEPING	33,783	0	0	33,783	9.00
10.00	01000	DIETARY	48,184	14,654	0	6,103	151,195
11.00	01100	CAFETERIA	13,585	7,931	0	3,303	0
13.00	01300	NURSING ADMINISTRATION	52,208	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	5,991	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	557,528	50,758	10,401	21,138	151,195
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,820	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,955	2,621	0	1,092	0
60.00	06000	LABORATORY	36,945	454	0	189	0
65.00	06500	RESPIRATORY THERAPY	67,009	726	0	302	0
66.00	06600	PHYSICAL THERAPY	20,163	2,752	0	1,146	0
67.00	06700	OCCUPATIONAL THERAPY	19,494	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	21,393	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	587	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	96,024	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	86,891	958	0	399	0
74.00	07400	RENAL DIALYSIS	22,671	0	0	0	0
76.00	03950	WOUND CARE	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,194,760	80,854	10,401	33,672	151,195
NONREIMBURSABLE COST CENTERS							
194.00	07950	PROVIDER RELATIONS NRCC	3,134	266	0	111	0
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0
194.02	07952	NRCC VACANT SPACE	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	1,197,894	81,120	10,401	33,783	151,195

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 4/30/2024 1:27 pm
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		11.00	13.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	69,336					11.00
13.00	01300	3,909	56,117				13.00
16.00	01600	1,282	0	7,273			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	40,536	56,117	2,083	1,174,677	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	10	4,830	0	50.00
54.00	05400	3,352	0	89	38,824	0	54.00
60.00	06000	0	0	310	40,444	0	60.00
65.00	06500	6,703	0	3,107	102,167	0	65.00
66.00	06600	2,707	0	137	42,356	0	66.00
67.00	06700	2,701	0	109	22,304	0	67.00
68.00	06800	2,212	0	140	23,745	0	68.00
69.00	06900	0	0	385	972	0	69.00
71.00	07100	1,375	0	455	375,781	0	71.00
73.00	07300	3,822	0	364	97,811	0	73.00
74.00	07400	0	0	84	22,755	0	74.00
76.00	03950	0	0	0	0	0	76.00
SPECIAL PURPOSE COST CENTERS							
118.00		68,599	56,117	7,273	1,946,666	0	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	737	0	0	5,742	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	111,162	0	194.02
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		69,336	56,117	7,273	2,063,570	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 4/30/2024 1:27 pm
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03950	WOUND CARE	76.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950	PROVIDER RELATIONS NRCC	194.00
194.01	07951	NRCC SUBLEASED SPACE	194.01
194.02	07952	NRCC VACANT SPACE	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-2014

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
4/30/2024 1:27 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	166,356				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		146,045			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	10,483,483		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	105,816	105,816	1,622,420	-8,144,731	5.00
7.00 00700	OPERATION OF PLANT	0	0	406,877	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	0	426,100	0	9.00
10.00 01000	DIETARY	7,267	7,267	528,656	0	10.00
11.00 01100	CAFETERIA	3,933	3,933	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	723,181	0	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	80,161	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	25,172	25,172	4,165,519	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	18,282	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,300	1,300	182,153	0	54.00
60.00 06000	LABORATORY	225	225	0	0	60.00
65.00 06500	RESPIRATORY THERAPY	360	360	761,451	0	65.00
66.00 06600	PHYSICAL THERAPY	1,365	1,365	280,207	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	278,140	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	312,195	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	110,446	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	475	475	554,608	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00 03950	WOUND CARE	0	0	0	0	76.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	145,913	145,913	10,450,396	-8,144,731	118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	PROVIDER RELATIONS NRCC	132	132	33,087	0	194.00
194.01 07951	NRCC SUBLEASED SPACE	0	0	0	0	194.01
194.02 07952	NRCC VACANT SPACE	20,311	0	0	-111,162	194.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	910,469	853,769	25,989	8,144,731	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	5.473016	5.845931	0.002479	0.409659	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0	1,197,894	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	0.060251	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: 15-2014

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
4/30/2024 1:27 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	40,229				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,618			8.00
9.00	00900	HOUSEKEEPING	0	0	40,229		9.00
10.00	01000	DIETARY	7,267	0	7,267	12,618	10.00
11.00	01100	CAFETERIA	3,933	0	3,933	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	631
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	207
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	25,172	12,618	25,172	12,618	6,543
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,300	0	1,300	0	541
60.00	06000	LABORATORY	225	0	225	0	0
65.00	06500	RESPIRATORY THERAPY	360	0	360	0	1,082
66.00	06600	PHYSICAL THERAPY	1,365	0	1,365	0	437
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	436
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	357
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	222
73.00	07300	DRUGS CHARGED TO PATIENTS	475	0	475	0	617
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03950	WOUND CARE	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,097	12,618	40,097	12,618	11,073
NONREIMBURSABLE COST CENTERS							
194.00	07950	PROVIDER RELATIONS NRCC	132	0	132	0	119
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0
194.02	07952	NRCC VACANT SPACE	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	1,874,706	243,358	790,401	1,608,772	578,388
203.00		Unit cost multiplier (Wkst. B, Part I)	46.600860	19.286575	19.647543	127.498177	51.678699
204.00		Cost to be allocated (per Wkst. B, Part II)	81,120	10,401	33,783	151,195	69,336
205.00		Unit cost multiplier (Wkst. B, Part II)	2.016456	0.824299	0.839767	11.982485	6.195139
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-2014

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1
Date/Time Prepared:
4/30/2024 1:27 pm

Cost Center Description		NURSING ADMINISTRATIVE (NURSING FTE'S)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
		13.00	16.00	
GENERAL SERVICE COST CENTERS				
1.00	00100			1.00
2.00	00200			2.00
4.00	00400			4.00
5.00	00500			5.00
7.00	00700			7.00
8.00	00800			8.00
9.00	00900			9.00
10.00	01000			10.00
11.00	01100			11.00
13.00	01300	55		13.00
16.00	01600	0	162,905,133	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	55	46,282,446	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	0	214,597	50.00
54.00	05400	0	1,988,027	54.00
60.00	06000	0	6,894,945	60.00
65.00	06500	0	70,344,794	65.00
66.00	06600	0	3,034,113	66.00
67.00	06700	0	2,414,634	67.00
68.00	06800	0	3,102,270	68.00
69.00	06900	0	8,554,378	69.00
71.00	07100	0	10,117,465	71.00
73.00	07300	0	8,085,967	73.00
74.00	07400	0	1,871,497	74.00
76.00	03950	0	0	76.00
SPECIAL PURPOSE COST CENTERS				
118.00		55	162,905,133	118.00
NONREIMBURSABLE COST CENTERS				
194.00	07950	0	0	194.00
194.01	07951	0	0	194.01
194.02	07952	0	0	194.02
200.00				200.00
201.00				201.00
202.00		1,254,091	150,872	202.00
203.00		22,801.654545	0.000926	203.00
204.00		56,117	7,273	204.00
205.00		1,020.309091	0.000045	205.00
206.00				206.00
207.00				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 4/30/2024 1:27 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00		4.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	18,198,987		18,198,987	315,220	18,514,207	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	112,979		112,979	0	112,979	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	512,604		512,604	0	512,604	54.00
60.00	06000 LABORATORY	885,678		885,678	0	885,678	60.00
65.00	06500 RESPIRATORY THERAPY	1,712,697	0	1,712,697	0	1,712,697	65.00
66.00	06600 PHYSICAL THERAPY	587,574	0	587,574	0	587,574	66.00
67.00	06700 OCCUPATIONAL THERAPY	480,866	0	480,866	0	480,866	67.00
68.00	06800 SPEECH PATHOLOGY	521,838	0	521,838	0	521,838	68.00
69.00	06900 ELECTROCARDIOLOGY	21,644		21,644	0	21,644	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,267,456		2,267,456	0	2,267,456	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,103,785		2,103,785	0	2,103,785	73.00
74.00	07400 RENAL DIALYSIS	532,152		532,152	0	532,152	74.00
76.00	03950 WOUND CARE	0		0	0	0	76.00
200.00	Subtotal (see instructions)	27,938,260	0	27,938,260	315,220	28,253,480	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	27,938,260	0	27,938,260	315,220	28,253,480	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 4/30/2024 1:27 pm
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Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
Title XVIII Hospital PPS						
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46,282,446			30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	214,597	0	0.526471	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,988,027	0	0.257846	54.00
60.00	06000	LABORATORY	6,894,945	0	0.128453	60.00
65.00	06500	RESPIRATORY THERAPY	70,344,794	0	0.024347	65.00
66.00	06600	PHYSICAL THERAPY	3,034,113	0	0.193656	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,414,634	0	0.199147	67.00
68.00	06800	SPEECH PATHOLOGY	3,102,270	0	0.168212	68.00
69.00	06900	ELECTROCARDIOLOGY	8,554,378	0	0.002530	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,117,465	0	0.224113	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,085,967	0	0.260177	73.00
74.00	07400	RENAL DIALYSIS	1,871,497	0	0.284346	74.00
76.00	03950	WOUND CARE	0	0	0.000000	76.00
200.00		Subtotal (see instructions)	162,905,133	0		200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	162,905,133	0		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 4/30/2024 1:27 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital
		11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.526471		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.257846		54.00
60.00	06000 LABORATORY	0.128453		60.00
65.00	06500 RESPIRATORY THERAPY	0.024347		65.00
66.00	06600 PHYSICAL THERAPY	0.193656		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.199147		67.00
68.00	06800 SPEECH PATHOLOGY	0.168212		68.00
69.00	06900 ELECTROCARDIOLOGY	0.002530		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.224113		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.260177		73.00
74.00	07400 RENAL DIALYSIS	0.284346		74.00
76.00	03950 WOUND CARE	0.000000		76.00
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: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 4/30/2024 1:27 pm
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Hospital		PPS	
				Title XIX			
				Total Costs	RCE Disallowance		Total Costs
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	18,198,987		18,198,987	315,220	18,514,207	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	112,979		112,979	0	112,979	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	512,604		512,604	0	512,604	54.00
60.00	06000 LABORATORY	885,678		885,678	0	885,678	60.00
65.00	06500 RESPIRATORY THERAPY	1,712,697	0	1,712,697	0	1,712,697	65.00
66.00	06600 PHYSICAL THERAPY	587,574	0	587,574	0	587,574	66.00
67.00	06700 OCCUPATIONAL THERAPY	480,866	0	480,866	0	480,866	67.00
68.00	06800 SPEECH PATHOLOGY	521,838	0	521,838	0	521,838	68.00
69.00	06900 ELECTROCARDIOLOGY	21,644		21,644	0	21,644	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,267,456		2,267,456	0	2,267,456	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,103,785		2,103,785	0	2,103,785	73.00
74.00	07400 RENAL DIALYSIS	532,152		532,152	0	532,152	74.00
76.00	03950 WOUND CARE	0		0	0	0	76.00
200.00	Subtotal (see instructions)	27,938,260	0	27,938,260	315,220	28,253,480	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	27,938,260	0	27,938,260	315,220	28,253,480	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 4/30/2024 1:27 pm	
			Title XIX	Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46,282,446			30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	214,597	0	0.526471	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,988,027	0	0.257846	54.00
60.00	06000	LABORATORY	6,894,945	0	0.128453	60.00
65.00	06500	RESPIRATORY THERAPY	70,344,794	0	0.024347	65.00
66.00	06600	PHYSICAL THERAPY	3,034,113	0	0.193656	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,414,634	0	0.199147	67.00
68.00	06800	SPEECH PATHOLOGY	3,102,270	0	0.168212	68.00
69.00	06900	ELECTROCARDIOLOGY	8,554,378	0	0.002530	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,117,465	0	0.224113	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,085,967	0	0.260177	73.00
74.00	07400	RENAL DIALYSIS	1,871,497	0	0.284346	74.00
76.00	03950	WOUND CARE	0	0	0.000000	76.00
200.00		Subtotal (see instructions)	162,905,133	0		200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	162,905,133	0		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 4/30/2024 1:27 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital
		11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.526471		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.257846		54.00
60.00	06000 LABORATORY	0.128453		60.00
65.00	06500 RESPIRATORY THERAPY	0.024347		65.00
66.00	06600 PHYSICAL THERAPY	0.193656		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.199147		67.00
68.00	06800 SPEECH PATHOLOGY	0.168212		68.00
69.00	06900 ELECTROCARDIOLOGY	0.002530		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.224113		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.260177		73.00
74.00	07400 RENAL DIALYSIS	0.284346		74.00
76.00	03950 WOUND CARE	0.000000		76.00
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: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part II Date/Time Prepared: 4/30/2024 1:27 pm
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Cost Center Description	Title XIX			Hospital	PPS			
	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	112,979	4,830	108,149	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	512,604	38,824	473,780	0	0	54.00
60.00	06000	LABORATORY	885,678	40,444	845,234	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,712,697	102,167	1,610,530	0	0	65.00
66.00	06600	PHYSICAL THERAPY	587,574	42,356	545,218	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	480,866	22,304	458,562	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	521,838	23,745	498,093	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	21,644	972	20,672	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,267,456	375,781	1,891,675	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,103,785	97,811	2,005,974	0	0	73.00
74.00	07400	RENAL DIALYSIS	532,152	22,755	509,397	0	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
200.00		Subtotal (sum of lines 50 thru 199)	9,739,273	771,989	8,967,284	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	9,739,273	771,989	8,967,284	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY	Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part II Date/Time Prepared: 4/30/2024 1:27 pm
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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)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	112,979	214,597	0.526471		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	512,604	1,988,027	0.257846		54.00
60.00	06000 LABORATORY	885,678	6,894,945	0.128453		60.00
65.00	06500 RESPIRATORY THERAPY	1,712,697	70,344,794	0.024347		65.00
66.00	06600 PHYSICAL THERAPY	587,574	3,034,113	0.193656		66.00
67.00	06700 OCCUPATIONAL THERAPY	480,866	2,414,634	0.199147		67.00
68.00	06800 SPEECH PATHOLOGY	521,838	3,102,270	0.168212		68.00
69.00	06900 ELECTROCARDIOLOGY	21,644	8,554,378	0.002530		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,267,456	10,117,465	0.224113		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,103,785	8,085,967	0.260177		73.00
74.00	07400 RENAL DIALYSIS	532,152	1,871,497	0.284346		74.00
76.00	03950 WOUND CARE	0	0	0.000000		76.00
200.00	Subtotal (sum of lines 50 thru 199)	9,739,273	116,622,687			200.00
201.00	Less Observation Beds	0	0			201.00
202.00	Total (line 200 minus line 201)	9,739,273	116,622,687			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-2014		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part I Date/Time Prepared: 4/30/2024 1:27 pm	
Title XVIII			Hospital		PPS		
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,174,677	0	1,174,677	12,618	93.10	30.00
200.00	Total (lines 30 through 199)	1,174,677		1,174,677	12,618		200.00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
	6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	5,013	466,710				
200.00	Total (lines 30 through 199)	5,013	466,710				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prepared: 4/30/2024 1:27 pm
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Cost Center Description		Capital Related Cost (from Wkst. C, 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	4,830	214,597	0.022507	99,898	2,248	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	38,824	1,988,027	0.019529	862,930	16,852	54.00
60.00	06000 LABORATORY	40,444	6,894,945	0.005866	3,020,377	17,718	60.00
65.00	06500 RESPIRATORY THERAPY	102,167	70,344,794	0.001452	30,857,272	44,805	65.00
66.00	06600 PHYSICAL THERAPY	42,356	3,034,113	0.013960	1,203,281	16,798	66.00
67.00	06700 OCCUPATIONAL THERAPY	22,304	2,414,634	0.009237	1,020,542	9,427	67.00
68.00	06800 SPEECH PATHOLOGY	23,745	3,102,270	0.007654	1,189,269	9,103	68.00
69.00	06900 ELECTROCARDIOLOGY	972	8,554,378	0.000114	3,554,411	405	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	375,781	10,117,465	0.037142	4,327,125	160,718	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	97,811	8,085,967	0.012096	2,907,524	35,169	73.00
74.00	07400 RENAL DIALYSIS	22,755	1,871,497	0.012159	1,099,171	13,365	74.00
76.00	03950 WOUND CARE	0	0	0.000000	0	0	76.00
200.00	Total (lines 50 through 199)	771,989	116,622,687		50,141,800	326,608	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-2014		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part III Date/Time Prepared: 4/30/2024 1:27 pm		
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS			1A	1.00	2A	2.00	3.00		
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
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 col. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
INPATIENT ROUTINE SERVICE COST CENTERS			4.00	5.00	6.00	7.00	8.00		
30.00	03000	ADULTS & PEDIATRICS	0	0	12,618	0.00	5,013	30.00	
200.00		Total (lines 30 through 199)		0	12,618		5,013	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
INPATIENT ROUTINE SERVICE COST CENTERS			9.00						
30.00	03000	ADULTS & PEDIATRICS	0						30.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-2014		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 4/30/2024 1:27 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
			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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
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: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 4/30/2024 1:27 pm
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 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	214,597	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,988,027	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	6,894,945	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	70,344,794	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,034,113	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,414,634	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,102,270	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	8,554,378	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	10,117,465	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,085,967	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,871,497	0.000000	74.00
76.00	03950	WOUND CARE	0	0	0	0	0.000000	76.00
200.00		Total (lines 50 through 199)	0	0	0	116,622,687		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 4/30/2024 1:27 pm
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Cost Center Description	Title XVIII			Hospital	PPS	
	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	99,898	0	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.000000	862,930	0	0	0	54.00
60.00 06000 LABORATORY	0.000000	3,020,377	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.000000	30,857,272	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.000000	1,203,281	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	1,020,542	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	1,189,269	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	3,554,411	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,327,125	0	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	2,907,524	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0.000000	1,099,171	0	0	0	74.00
76.00 03950 WOUND CARE	0.000000	0	0	0	0	76.00
200.00 Total (lines 50 through 199)		50,141,800	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-2014		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part I Date/Time Prepared: 4/30/2024 1:27 pm	
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)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,174,677	0	1,174,677	12,618	93.10	30.00
200.00	Total (lines 30 through 199)	1,174,677		1,174,677	12,618		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	268	24,951				30.00
200.00	Total (lines 30 through 199)	268	24,951				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 15-2014		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part II Date/Time Prepared: 4/30/2024 1:27 pm	
Cost Center Description			Title XIX		Hospital		PPS	
			Capital Related Cost (from Wkst. C, Part I, 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	4,830	214,597	0.022507	1,127	25	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,824	1,988,027	0.019529	22,885	447	54.00
60.00	06000	LABORATORY	40,444	6,894,945	0.005866	110,563	649	60.00
65.00	06500	RESPIRATORY THERAPY	102,167	70,344,794	0.001452	2,673,108	3,881	65.00
66.00	06600	PHYSICAL THERAPY	42,356	3,034,113	0.013960	26,973	377	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,304	2,414,634	0.009237	21,146	195	67.00
68.00	06800	SPEECH PATHOLOGY	23,745	3,102,270	0.007654	23,249	178	68.00
69.00	06900	ELECTROCARDIOLOGY	972	8,554,378	0.000114	85,243	10	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	375,781	10,117,465	0.037142	185,242	6,880	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	97,811	8,085,967	0.012096	212,990	2,576	73.00
74.00	07400	RENAL DIALYSIS	22,755	1,871,497	0.012159	31,679	385	74.00
76.00	03950	WOUND CARE	0	0	0.000000	0	0	76.00
200.00		Total (lines 50 through 199)	771,989	116,622,687		3,394,205	15,603	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-2014		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part III Date/Time Prepared: 4/30/2024 1:27 pm		
Cost Center Description			Title XIX		Hospital		PPS		
			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	
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 col. 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	12,618	0.00	268	30.00	
200.00		Total (lines 30 through 199)		0	12,618		268	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
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 4/30/2024 1:27 pm
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Cost Center Description	Title XIX			Hospital	PPS		
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	76.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 4/30/2024 1:27 pm
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Cost Center Description	Title XIX		Hospital		PPS			
	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 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	214,597	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,988,027	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	6,894,945	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	70,344,794	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,034,113	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,414,634	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,102,270	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	8,554,378	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	10,117,465	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,085,967	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,871,497	0.000000	74.00
76.00	03950	WOUND CARE	0	0	0	0	0.000000	76.00
200.00		Total (lines 50 through 199)	0	0	0	116,622,687		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 4/30/2024 1:27 pm
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Cost Center Description	Title XIX			Hospital		PPS
	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	1,127	0	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.000000	22,885	0	0	0	54.00
60.00 06000 LABORATORY	0.000000	110,563	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.000000	2,673,108	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.000000	26,973	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	21,146	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	23,249	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	85,243	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	185,242	0	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	212,990	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0.000000	31,679	0	0	0	74.00
76.00 03950 WOUND CARE	0.000000	0	0	0	0	76.00
200.00 Total (lines 50 through 199)		3,394,205	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 4/30/2024 1:27 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,618	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,618	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)		12,618	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		5,013	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		18,514,207	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		18,514,207	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)		18,514,207	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,467.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		7,355,525	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)		7,355,525	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 4/30/2024 1:27 pm	
Title XVIII			Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,098,438	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)					11,453,963	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)					466,710	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					326,608	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					793,318	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					10,660,645	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
55.01 Permanent adjustment amount per discharge					0.00	55.01
55.02 Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only): for CAH, see instructions					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-2014		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 4/30/2024 1:27 pm	
Cost Center Description		Title XVIII		Hospital		PPS	
89.00 Observation bed cost (line 87 x line 88) (see instructions)						1.00 0 89.00	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,174,677	18,514,207	0.063447	0	0	90.00
91.00	Nursing Program cost	0	18,514,207	0.000000	0	0	91.00
92.00	Allied health cost	0	18,514,207	0.000000	0	0	92.00
93.00	All other Medical Education	0	18,514,207	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 4/30/2024 1:27 pm
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,618	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,618	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)		12,618	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		268	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		18,514,207	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		18,514,207	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)		18,514,207	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,467.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		393,234	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)		393,234	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 4/30/2024 1:27 pm		
Cost Center Description			Title XIX		Hospital	PPS	
			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
			1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						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)						205,277 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)						598,511 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)						24,951 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						15,603 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						40,554 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)						557,957 53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						0 54.00
55.00	Target amount per discharge						0.00 55.00
55.01	Permanent adjustment amount per discharge						0.00 55.01
55.02	Adjustment amount per discharge (contractor use only)						0.00 55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)						0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0 57.00
58.00	Bonus payment (see instructions)						0 58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)						0.00 59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						0.00 60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)						0 61.00
62.00	Relief payment (see instructions)						0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only): for CAH, see instructions						0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)						0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00 88.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-2014		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 4/30/2024 1:27 pm	
Cost Center Description		Title XIX		Hospital		PPS	
Cost Center Description						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,174,677	18,514,207	0.063447	0	0	90.00
91.00	Nursing Program cost	0	18,514,207	0.000000	0	0	91.00
92.00	Allied health cost	0	18,514,207	0.000000	0	0	92.00
93.00	All other Medical Education	0	18,514,207	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 4/30/2024 1:27 pm	
Cost Center Description		Ratio of Cost To Charges	Hospital	PPS	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		14,899,057		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.526471	99,898	52,593	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.257846	862,930	222,503	54.00
60.00	06000 LABORATORY	0.128453	3,020,377	387,976	60.00
65.00	06500 RESPIRATORY THERAPY	0.024347	30,857,272	751,282	65.00
66.00	06600 PHYSICAL THERAPY	0.193656	1,203,281	233,023	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.199147	1,020,542	203,238	67.00
68.00	06800 SPEECH PATHOLOGY	0.168212	1,189,269	200,049	68.00
69.00	06900 ELECTROCARDIOLOGY	0.002530	3,554,411	8,993	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.224113	4,327,125	969,765	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.260177	2,907,524	756,471	73.00
74.00	07400 RENAL DIALYSIS	0.284346	1,099,171	312,545	74.00
76.00	03950 WOUND CARE	0.000000	0	0	76.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		50,141,800	4,098,438	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		50,141,800		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 4/30/2024 1:27 pm	
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		664,590		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.526471	1,127	593	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.257846	22,885	5,901	54.00
60.00	06000 LABORATORY	0.128453	110,563	14,202	60.00
65.00	06500 RESPIRATORY THERAPY	0.024347	2,673,108	65,082	65.00
66.00	06600 PHYSICAL THERAPY	0.193656	26,973	5,223	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.199147	21,146	4,211	67.00
68.00	06800 SPEECH PATHOLOGY	0.168212	23,249	3,911	68.00
69.00	06900 ELECTROCARDIOLOGY	0.002530	85,243	216	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.224113	185,242	41,515	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.260177	212,990	55,415	73.00
74.00	07400 RENAL DIALYSIS	0.284346	31,679	9,008	74.00
76.00	03950 WOUND CARE	0.000000	0	0	76.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,394,205	205,277	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		3,394,205		202.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-2014		Period: From 01/01/2023 To 12/31/2023		Worksheet E-1 Part I Date/Time Prepared: 4/30/2024 1:27 pm	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		10,269,396		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	08/25/2023	1,133,395		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	12/15/2023	409,932		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)		723,463		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)		10,992,859		0		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0		6.01
6.02	SETTLEMENT TO PROGRAM		640,852		0		6.02
7.00	Total Medicare program liability (see instructions)		10,352,007		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		Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part IV Date/Time Prepared: 4/30/2024 1:27 pm
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)			9,147,940 1.00
1.01	Full standard payment amount			7,482,893 1.01
1.02	Short stay outlier standard payment amount			1,649,846 1.02
1.03	Site neutral payment amount - Cost			0 1.03
1.04	Site neutral payment amount - IPPS comparable			15,201 1.04
2.00	Outlier Payments			1,835,827 2.00
3.00	Total PPS Payments (sum of lines 1 and 2)			10,983,767 3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)			0 4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)			0 5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)			0 6.00
7.00	Subtotal (see instructions)			10,983,767 7.00
8.00	Primary payer payments			62,540 8.00
9.00	Subtotal (line 7 less line 8).			10,921,227 9.00
10.00	Deductibles			24,528 10.00
11.00	Subtotal (line 9 minus line 10)			10,896,699 11.00
12.00	Coinurance			509,003 12.00
13.00	Subtotal (line 11 minus line 12)			10,387,696 13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			270,117 14.00
15.00	Adjusted reimbursable bad debts (see instructions)			175,576 15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			224,557 16.00
17.00	Subtotal (sum of lines 13 and 15)			10,563,272 17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 18.00
19.00	Other pass through costs (see instructions)			0 19.00
20.00	Outlier payments reconciliation			0 20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 21.50
21.98	Recovery of accelerated depreciation.			0 21.98
21.99	Demonstration payment adjustment amount before sequestration			0 21.99
22.00	Total amount payable to the provider (see instructions)			10,563,272 22.00
22.01	Sequestration adjustment (see instructions)			211,265 22.01
22.02	Demonstration payment adjustment amount after sequestration			0 22.02
23.00	Interim payments			10,992,859 23.00
24.00	Tentative settlement (for contractor use only)			0 24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)			-640,852 25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 26.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)			1,835,827 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money (see instructions)			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-2014	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 4/30/2024 1:27 pm	
		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			0	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		3,394,205	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		3,394,205	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		3,394,205	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		3,394,205	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		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	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	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: 15-2014

Period:
From 01/01/2023
To 12/31/2023

Worksheet G

Date/Time Prepared:
4/30/2024 1:27 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	0	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	3,391,934	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	59,071	0	0	0	8.00
9.00	Other current assets	212,803	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,663,808	0	0	0	11.00
FIXED ASSETS						
12.00	Land	70,780	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	-55,082	0	0	0	14.00
15.00	Buildings	3,064,763	0	0	0	15.00
16.00	Accumulated depreciation	-1,697,116	0	0	0	16.00
17.00	Leasehold improvements	2,798,379	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	8,096,717	0	0	0	23.00
24.00	Accumulated depreciation	-6,343,210	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	5,935,231	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	2,308,352	0	0	0	32.00
33.00	Due from owners/officers	-19,578,865	0	0	0	33.00
34.00	Other assets	20,780	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	-17,249,733	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	-7,650,694	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,333,330	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,561,741	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,895,071	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	1,712,229	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,712,229	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,607,300	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-13,257,994	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-13,257,994	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	-7,650,694	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-2014

Period:
From 01/01/2023
To 12/31/2023

Worksheet G-1

Date/Time Prepared:
4/30/2024 1:27 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-11,004,302		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-2,023,814		0		2.00
3.00	Total (sum of line 1 and line 2)		-13,028,116		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	FUND BALANCE RECON	0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-13,028,116		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)		-13,028,116		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	FUND BALANCE RECON		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: 15-2014

Period:
From 01/01/2023
To 12/31/2023

Worksheet G-2
Parts I & II
Date/Time Prepared:
4/30/2024 1:27 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	46,282,446		46,282,446	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)	46,282,446		46,282,446	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	46,282,446		46,282,446	17.00
18.00	Ancillary services	116,622,687	0	116,622,687	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	162,905,133	0	162,905,133	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		27,963,896		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 BAD DEBT EXPENSE**	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)		27,963,896		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-2014

Period:
From 01/01/2023
To 12/31/2023

Worksheet G-3

Date/Time Prepared:
4/30/2024 1:27 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	162,905,133	1.00
2.00	Less contractual allowances and discounts on patients' accounts	137,593,136	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,311,997	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	27,963,896	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,651,899	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	29,182	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	2,549	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 REVENUE	4,829	24.00
24.01	PHYSICIAN REVENUE	1,659,966	24.01
24.02	BAD DEBT SETTLEMENT	0	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	1,696,526	25.00
26.00	Total (line 5 plus line 25)	-955,373	26.00
27.00	MANAGEMENT FEE	1,096,455	27.00
27.01	INTERCOMPANY INTEREST	-4,681	27.01
27.02	TAXES	-314,790	27.02
27.03	INTEREST EXPENSE	291,457	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	1,068,441	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,023,814	29.00