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: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 4/11/2024 3:17 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 4/11/2024 Time: 3:17 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GOOD SAMARITAN HOSPITAL (15-0042) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Matt Schuckman		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	Matt Schuckman			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	1,542,317	107,702	0	-379,260	1.00
2.00	SUBPROVIDER - IPF	0	13,941	988		299,205	2.00
3.00	SUBPROVIDER - IRF	0	-713	-35		-11,285	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	FAMILY PRACTICE 120 I	0		0		0	10.00
200.00	TOTAL	0	1,555,545	108,655	0	-91,340	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: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 4/11/2024 3:17 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 520 SOUTH 7TH STREET	PO Box:			1.00
2.00	City: VINCENNES	State: IN	Zip Code: 47591	County: KNOX	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	GOOD SAMARITAN HOSPITAL	150042	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	GOOD SAMARITAN HOSPITAL	15S042	99915	4	01/01/1984	N	P	O	4.00
5.00	Subprovider - IRF	GOOD SAMARITAN - REHAB	15T042	99915	5	01/01/2001	N	P	O	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	GOOD SAMARITAN HOME CENTER	157432	99915		06/27/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	GOOD SAMARITAN LINCOLN TRAIL HOSPICE	151526	99915		01/01/1984				14.00
15.00	Hospital-Based Health Clinic - RHC	GOOD SAMARITAN FAMILY PRACTICE 120	158577	99915		12/27/2023	N	O	O	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 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)	9		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	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.	2	N		23.00

		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.	405	112	58	97	1,963	416	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.	17	32	0	6	181		25.00

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

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	1		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.	01/01/2023	12/31/2023	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	Y	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	Y	Y		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.	Y			57.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		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.	Y	Y		60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.01	1	60.01

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 4/11/2024 3:17 pm

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.17	18.30	0.009204	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	INTERNAL MEDICINE	1400	0.49	24.60	0.019530	67.00

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	Y	5	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.	Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

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

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

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

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

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	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	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	483,019	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	N	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 4/11/2024 3:17 pm

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 4/11/2024 3:17 pm

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

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

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

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		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.	Y		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.	Y		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/08/2024	Y	03/08/2024	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 4/11/2024 3:17 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		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.	KYLE	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO, LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957	KCSMITH@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 4/11/2024 3:17 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.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 4/11/2024 3:17 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	69	25,185	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)		69	25,185	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	30	10,950	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		99	36,135	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	40.00	20	7,300		0	16.00
17.00	SUBPROVIDER - IRF	41.00	25	9,125		0	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	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	FAMILY PRACTICE 120	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		144				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: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 4/11/2024 3:17 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,497	405	9,713			1.00
2.00	HMO and other (see instructions)	3,537	2,230				2.00
3.00	HMO IPF Subprovider	537	1,464				3.00
4.00	HMO IRF Subprovider	533	219				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,497	405	9,713			7.00
8.00	INTENSIVE CARE UNIT	1,988	0	4,812			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		0	816			13.00
14.00	Total (see instructions)	6,485	405	15,341	39.57	1,368.63	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF	532	357	4,323	3.98	28.66	16.00
17.00	SUBPROVIDER - IRF	4,578	17	6,252	0.00	29.53	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	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	8.12	24.00
24.10	HOSPICE (non-distinct part)			404			24.10
25.00	CMHC - CMHC						25.00
26.00	FAMILY PRACTICE 120	0	0	6	0.00	0.06	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				43.55	1,435.00	27.00
28.00	Observation Bed Days		476	2,553			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	416	873			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 4/11/2024 3:17 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,690	94	4,032	1.00
2.00	HMO and other (see instructions)			709	860		2.00
3.00	HMO IPF Subprovider				282		3.00
4.00	HMO IRF Subprovider				18		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	1,690	94	4,032	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF	0.00	0	87	63	818	16.00
17.00	SUBPROVIDER - IRF	0.00	0	302	1	407	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	FAMILY PRACTICE 120	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 4/11/2024 3:17 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	110,193,141	0	110,193,141	2,935,332.00	37.54	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		9,092,375	0	9,092,375	36,359.00	250.07	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		21,835	0	21,835	465.00	46.96	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)		3,615,557	0	3,615,557	82,326.00	43.92	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)		25,752,706	1,572,092	27,324,798	678,943.00	40.25	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		4,236,110	0	4,236,110	90,077.00	47.03	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		638,804	0	638,804	4,485.00	142.43	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	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)		20,866,469	0	20,866,469			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		6,528,587	0	6,528,587			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		797,867	0	797,867			23.00
24.00	Wage-related costs (RHC/FQHC)		5,149	0	5,149			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		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	6,006,745	0	6,006,745	269,365.00	22.30	26.00
27.00	Administrative & General	5.00	7,853,050	0	7,853,050	202,798.00	38.72	27.00
28.00	Administrative & General under contract (see inst.)		1,249,762	0	1,249,762	8,828.00	141.57	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,576,329	0	2,576,329	93,185.00	27.65	30.00
31.00	Laundry & Linen Service	8.00	239,763	0	239,763	13,505.00	17.75	31.00
32.00	Housekeeping	9.00	2,339,766	0	2,339,766	124,101.00	18.85	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,906,448	-1,401,049	505,399	21,983.00	22.99	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,401,049	1,401,049	74,394.00	18.83	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,284,261	0	2,284,261	52,783.00	43.28	38.00
39.00	Central Services and Supply	14.00	386,217	0	386,217	15,978.00	24.17	39.00
40.00	Pharmacy	15.00	3,202,203	0	3,202,203	69,446.00	46.11	40.00
41.00	Medical Records & Medical Records Library	16.00	4,038,556	0	4,038,556	123,434.00	32.72	41.00
42.00	Social Service	17.00	345,494	0	345,494	7,166.00	48.21	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part III Date/Time Prepared: 4/11/2024 3:17 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		98,713,136	0	98,713,136	2,825,010.00	34.94	1.00
2.00	Excluded area salaries (see instructions)		25,752,706	1,572,092	27,324,798	678,943.00	40.25	2.00
3.00	Subtotal salaries (line 1 minus line 2)		72,960,430	-1,572,092	71,388,338	2,146,067.00	33.26	3.00
4.00	Subtotal other wages & related costs (see inst.)		4,874,914	0	4,874,914	94,562.00	51.55	4.00
5.00	Subtotal wage-related costs (see inst.)		20,866,469	0	20,866,469	0.00	29.23	5.00
6.00	Total (sum of lines 3 thru 5)		98,701,813	-1,572,092	97,129,721	2,240,629.00	43.35	6.00
7.00	Total overhead cost (see instructions)		32,428,594	0	32,428,594	1,076,966.00	30.11	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 4/11/2024 3:17 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	4,563,535	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)	14,610,500	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	293,116	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	112,135	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)	228,469	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	591,201	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	7,573,845	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	26,266	21.00
22.00	Day Care Cost and Allowances	199,005	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	28,198,072	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part V Date/Time Prepared: 4/11/2024 3:17 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	4,236,110	28,198,072	1.00
2.00	Hospital	4,236,110	28,198,072	2.00
3.00	SUBPROVIDER - IPF	0	0	3.00
4.00	SUBPROVIDER - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0042 Component CCN: 15-8577	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 4/11/2024 3:17 pm
		RHC I	Cost

Line	Description	1.00	Line
	Clinic Address and Identification		
1.00	Street	406 N. 1ST, SUITE C	1.00

Line	Description	City	State	ZIP Code	Line
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	VINCENNES	IN	47591	2.00

Line	Description	1.00	Line
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

Line	Description	Grant Award	Date	Line
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

Line	Description	1.00	2.00	Line
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

Line	Description	Sunday from	Sunday to	Monday from	Monday to	Tuesday from	Line
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:30	16:30	08:30	11.00

Line	Description	1.00	2.00	Line
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.	N	0	13.01

Line	Description	Provider name	CCN	Line
		1.00	2.00	
14.00	RHC/FQHC name, CCN			14.00

Line	Description	Y/N	V	XVIII	XIX	Total Visits	Line
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0042 Component CCN: 15-8577	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 4/11/2024 3:17 pm
		RHC I	Cost

		County	
		4.00	
2.00	City, State, ZIP Code, County	KNOX	2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	08:30	16:30	08:30	16:30	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:30	16:30				11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-9 PARTS I THROUGH IV | Date/Time Prepared: 4/11/2024 3:17 pm

Hospice I

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	3,274	181	56	3,511	11.00
12.00	Hospice Inpatient Respite Care	5	0	0	5	12.00
13.00	Hospice General Inpatient Care	166	0	0	166	13.00
14.00	Total Hospice Days	3,445	181	56	3,682	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II | Date/Time Prepared: 4/11/2024 3:17 pm

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.261462	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	16,346,949	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	102,501,350	6.00
7.00	Medicaid cost (line 1 times line 6)	26,800,208	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	10,453,259	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	10,453,259	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	5,136,749	585,357	5,722,106	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,343,065	555,752	1,898,817	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	1,343,065	555,752	1,898,817	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	40,086	25.01
26.00	Bad debt amount (see instructions)	13,393,152	26.00
27.00	Medicare reimbursable bad debts (see instructions)	285,977	27.00
27.01	Medicare allowable bad debts (see instructions)	439,965	27.01
28.00	Non-Medicare bad debt amount (see instructions)	12,953,187	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	3,540,754	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	5,439,571	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	15,892,830	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 4/11/2024 3:17 pm

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.246763	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		5.00
6.00	Medicaid charges		6.00
7.00	Medicaid cost (line 1 times line 6)		7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP		9.00
10.00	Stand-alone CHIP charges		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	5,136,756	576,825	5,713,581	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,267,561	547,128	1,814,689	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	1,267,561	547,128	1,814,689	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	39,426	25.01
26.00	Bad debt amount (see instructions)	13,265,240	26.00
27.00	Medicare reimbursable bad debts (see instructions)	274,451	27.00
27.01	Medicare allowable bad debts (see instructions)	422,232	27.01
28.00	Non-Medicare bad debt amount (see instructions)	12,843,008	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	3,316,960	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	5,131,649	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,131,649	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		16,347,994	16,347,994	5,562,128	21,910,122	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		40,088	40,088	0	40,088	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	669,803	1,803,871	2,473,674	25,941,557	28,415,231	4.00
4.01	00401	COMMUNICATIONS	324,521	101,988	426,509	-101,382	325,127	4.01
4.02	00402	PURCHASING & RECEIVING	762,616	715,135	1,477,751	-304,631	1,173,120	4.02
4.03	00403	REGISTRATION	1,806,704	651,282	2,457,986	-634,841	1,823,145	4.03
4.04	00404	PATIENT ACCOUNTS	2,443,101	2,410,422	4,853,523	-744,901	4,108,622	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	7,853,050	29,385,627	37,238,677	-2,397,324	34,841,353	5.00
7.00	00700	OPERATION OF PLANT	2,576,329	5,865,649	8,441,978	-741,119	7,700,859	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	239,763	214,533	454,296	-114,864	339,432	8.00
9.00	00900	HOUSEKEEPING	2,339,766	961,216	3,300,982	-706,736	2,594,246	9.00
10.00	01000	DIETARY	1,906,448	1,991,080	3,897,528	-3,009,641	887,887	10.00
11.00	01100	CAFETERIA	0	0	0	2,461,366	2,461,366	11.00
13.00	01300	NURSING ADMINISTRATION	2,284,261	2,624,086	4,908,347	-417,349	4,490,998	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	386,217	324,699	710,916	-110,272	600,644	14.00
15.00	01500	PHARMACY	3,202,203	21,113,178	24,315,381	-20,736,541	3,578,840	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,038,556	1,682,897	5,721,453	-1,117,243	4,604,210	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	345,494	324,659	670,153	-85,298	584,855	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	3,615,557	3,615,557	19,182	3,634,739	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,002,388	1,110,500	3,112,888	-434,724	2,678,164	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	278,171	65,249	343,420	-51,895	291,525	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,681,380	8,233,679	15,915,059	-2,140,034	13,775,025	30.00
31.00	03100	INTENSIVE CARE UNIT	3,479,331	1,714,551	5,193,882	-663,026	4,530,856	31.00
40.00	04000	SUBPROVIDER - IPF	2,236,192	1,052,463	3,288,655	-453,517	2,835,138	40.00
41.00	04100	SUBPROVIDER - IRF	1,993,493	752,228	2,745,721	-465,566	2,280,155	41.00
43.00	04300	NURSERY	0	0	0	309,790	309,790	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,308,341	6,078,551	9,386,892	-3,520,491	5,866,401	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	845,525	1,117,860	1,963,385	-350,289	1,613,096	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	187,235	187,235	52.00
53.00	05300	ANESTHESIOLOGY	2,861,645	2,111,345	4,972,990	-526,706	4,446,284	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,961,683	6,370,152	11,331,835	-2,338,671	8,993,164	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,937,306	3,250,609	6,187,915	-683,233	5,504,682	55.00
60.00	06000	LABORATORY	2,441,210	6,019,748	8,460,958	-534,759	7,926,199	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,724,194	2,460,357	5,184,551	-990,261	4,194,290	65.00
66.00	06600	PHYSICAL THERAPY	5,788,311	1,617,130	7,405,441	-1,375,986	6,029,455	66.00
69.00	06900	ELECTROCARDIOLOGY	5,104,267	3,176,018	8,280,285	-2,098,916	6,181,369	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	889,678	1,139,699	2,029,377	-183,261	1,846,116	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,675,266	3,675,266	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,249,606	4,249,606	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	19,923,050	19,923,050	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,221,011	2,638,082	3,859,093	-1,744,672	2,114,421	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	93,493	383,376	476,869	-19,466	457,403	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	1,593,927	624,829	2,218,756	-2,194,449	24,307	88.00
90.00	09000	CLINIC	157,578	29,962	187,540	-28,709	158,831	90.00
90.01	04950	WOUND CLINIC	372,480	1,260,767	1,633,247	-622,903	1,010,344	90.01
91.00	09100	EMERGENCY	4,702,789	3,366,786	8,069,575	-1,026,568	7,043,007	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	95,066	82,051	177,117	-18,497	158,620	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		5,029,545	5,029,545	-5,029,545	0	113.00
116.00	11600	HOSPICE	515,690	522,975	1,038,665	-156,850	881,815	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	89,463,981	150,382,473	239,846,454	3,454,044	243,300,498	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,455,912	7,728,341	21,184,253	-1,312,678	19,871,575	192.00
192.01	19201	FP PETERSBURG	130,307	148,824	279,131	-23,708	255,423	192.01
192.02	19202	PEDIATRICS	920,415	576,325	1,496,740	-296,727	1,200,013	192.02
192.03	19203	WASHINGTON PRIMARY CARE	1,426,504	531,865	1,958,369	-310,985	1,647,384	192.03
192.04	19204	FQHC	0	282,420	282,420	-282,492	-72	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	118,041	34,597	152,638	-20,454	132,184	194.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.01	07960	CCBHC GRANTS	1,011,558	1,275,532	2,287,090	-301,143	1,985,947	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	260,331	563,141	823,472	-59,377	764,095	194.02
194.03	07953	MH RESIDENTIAL	274,107	88,609	362,716	-64,279	298,437	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	160	36,545	36,705	-47	36,658	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	3,131,825	1,125,474	4,257,299	-782,154	3,475,145	194.09
194.10	07951	BEIRHAUS BUILDING	0	116,137	116,137	0	116,137	194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	110,193,141	162,890,283	273,083,424	0	273,083,424	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,603,625	20,306,497	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	40,088	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-610	28,414,621	4.00
4.01	00401	COMMUNICATIONS	-114,387	210,740	4.01
4.02	00402	PURCHASING & RECEIVING	-392,942	780,178	4.02
4.03	00403	REGISTRATION	0	1,823,145	4.03
4.04	00404	PATIENT ACCOUNTS	-177,024	3,931,598	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	-15,156,746	19,684,607	5.00
7.00	00700	OPERATION OF PLANT	-43,681	7,657,178	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	339,432	8.00
9.00	00900	HOUSEKEEPING	-33,311	2,560,935	9.00
10.00	01000	DIETARY	0	887,887	10.00
11.00	01100	CAFETERIA	-1,233,900	1,227,466	11.00
13.00	01300	NURSING ADMINISTRATION	-177,435	4,313,563	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	600,644	14.00
15.00	01500	PHARMACY	-262,168	3,316,672	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-113,529	4,490,681	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
17.01	01701	MENTAL HEALTH OH	-19,215	565,640	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	3,634,739	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	168,000	2,846,164	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	-18,819	272,706	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-3,668,633	10,106,392	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,530,856	31.00
40.00	04000	SUBPROVIDER - IPF	-45	2,835,093	40.00
41.00	04100	SUBPROVIDER - IRF	-146	2,280,009	41.00
43.00	04300	NURSERY	0	309,790	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-1,700,407	4,165,994	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
51.01	05101	ENDOSCOPY	0	1,613,096	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	187,235	52.00
53.00	05300	ANESTHESIOLOGY	-3,789,393	656,891	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,397,945	7,595,219	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-2,414,035	3,090,647	55.00
60.00	06000	LABORATORY	-421,909	7,504,290	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	-1,786,820	2,407,470	65.00
66.00	06600	PHYSICAL THERAPY	-1,867,392	4,162,063	66.00
69.00	06900	ELECTROCARDIOLOGY	-3,186,831	2,994,538	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	-806,192	1,039,924	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,675,266	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,249,606	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-395,348	19,527,702	73.00
75.00	07500	ASC (NON-DISTINCT PART)	-75,786	2,038,635	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	-208,995	248,408	76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	FAMILY PRACTICE 120	0	24,307	88.00
90.00	09000	CLINIC	0	158,831	90.00
90.01	04950	WOUND CLINIC	-17,500	992,844	90.01
91.00	09100	EMERGENCY	-1,266,599	5,776,408	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	158,620	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	881,815	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-42,183,368	201,117,130	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	19,871,575	192.00
192.01	19201	FP PETERSBURG	0	255,423	192.01
192.02	19202	PEDIATRICS	0	1,200,013	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	1,647,384	192.03
192.04	19204	FQHC	0	-72	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	132,184	194.00
194.01	07960	CCBHC GRANTS	0	1,985,947	194.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	764,095	194.02
194.03	07953	MH RESIDENTIAL	0	298,437	194.03
194.04	07954	UNUSED SPACE	0	0	194.04
194.05	07955	MOB	0	36,658	194.05
194.06	07956	FOUNDATION	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	3,475,145	194.09
194.10	07951	BEIRHAUS BUILDING	0	116,137	194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	-42,183,368	230,900,056	200.00

RECLASSIFICATIONS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 4/11/2024 3:17 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	19,923,050	1.00
	0		0	19,923,050	
	B - MEDICAL SUPPLIES CHARGED TO PATIENTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,675,266	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,249,606	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	0		0	7,924,872	
	C - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	26,017,558	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
39.00		0.00	0	0	39.00
40.00		0.00	0	0	40.00
41.00		0.00	0	0	41.00
42.00		0.00	0	0	42.00

RECLASSIFICATIONS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 4/11/2024 3:17 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
43.00		0.00	0	0	43.00
44.00		0.00	0	0	44.00
45.00		0.00	0	0	45.00
46.00		0.00	0	0	46.00
47.00		0.00	0	0	47.00
48.00		0.00	0	0	48.00
49.00		0.00	0	0	49.00
	0		0	26,017,558	
	D - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,029,545	1.00
	0		0	5,029,545	
	E - INSURANCE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	532,583	1.00
	0		0	532,583	
	F - DIETARY RECLASS				
1.00	CAFETERIA	11.00	1,401,049	1,060,317	1.00
	0		1,401,049	1,060,317	
	G - OB RECLASS				
1.00	NURSERY	43.00	278,493	31,297	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	168,319	18,916	2.00
	0		446,812	50,213	
	H - RESIDENT RECLASS				
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	19,182	1.00
	0		0	19,182	
	I - RHC RECLASS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	1,572,092	177,955	1.00
	TOTALS		1,572,092	177,955	
500.00	Grand Total: Increases		3,419,953	60,735,275	500.00

RECLASSIFICATIONS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 4/11/2024 3:17 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	19,923,050	0		1.00
	0		0	19,923,050			
	B - MEDICAL SUPPLIES CHARGED TO PATIENTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	76,001	0		1.00
2.00	PURCHASING & RECEIVING	4.02	0	464	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	17	0		3.00
4.00	OPERATION OF PLANT	7.00	0	2,868	0		4.00
5.00	HOUSEKEEPING	9.00	0	48	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,408	0		6.00
7.00	PHARMACY	15.00	0	65,329	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	147,168	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	53,338	0		9.00
10.00	SUBPROVIDER - IPF	40.00	0	1,336	0		10.00
11.00	SUBPROVIDER - IRF	41.00	0	10,196	0		11.00
12.00	OPERATING ROOM	50.00	0	2,694,801	0		12.00
13.00	ENDOSCOPY	51.01	0	146,967	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,249,990	0		14.00
15.00	RADIOLOGY-THERAPEUTIC	55.00	0	15,495	0		15.00
16.00	LABORATORY	60.00	0	6,388	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	203,705	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	88,949	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	1,135,871	0		19.00
20.00	NEURODIAGNOSTICS	70.01	0	1,977	0		20.00
21.00	ASC (NON-DISTINCT PART)	75.00	0	1,387,041	0		21.00
22.00	INPATIENT DIALYSIS	76.01	0	2,361	0		22.00
23.00	WOUND CLINIC	90.01	0	538,841	0		23.00
24.00	EMERGENCY	91.00	0	93,313	0		24.00
	0		0	7,924,872			
	C - EMPLOYEE BENEFITS						
1.00	COMMUNICATIONS	4.01		101,382	0		1.00
2.00	PURCHASING & RECEIVING	4.02		304,167	0		2.00
3.00	REGISTRATION	4.03		634,841	0		3.00
4.00	PATIENT ACCOUNTS	4.04		744,901	0		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00		1,864,724	0		5.00
6.00	OPERATION OF PLANT	7.00		738,251	0		6.00
7.00	LAUNDRY & LINEN SERVICE	8.00		114,864	0		7.00
8.00	HOUSEKEEPING	9.00		706,688	0		8.00
9.00	DIETARY	10.00		548,275	0		9.00
10.00	NURSING ADMINISTRATION	13.00		417,349	0		10.00
11.00	CENTRAL SERVICES & SUPPLY	14.00		107,864	0		11.00
12.00	PHARMACY	15.00		748,162	0		12.00
13.00	MEDICAL RECORDS & LIBRARY	16.00		1,117,243	0		13.00
14.00	MENTAL HEALTH OH	17.01		85,298	0		14.00
15.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00		434,724	0		15.00
16.00	PARAMED ED PRGM-LAB	23.01		51,895	0		16.00
17.00	ADULTS & PEDIATRICS	30.00		1,495,841	0		17.00
18.00	INTENSIVE CARE UNIT	31.00		609,688	0		18.00
19.00	SUBPROVIDER - IPF	40.00		452,181	0		19.00
20.00	SUBPROVIDER - IRF	41.00		455,370	0		20.00
21.00	OPERATING ROOM	50.00		825,690	0		21.00
22.00	ENDOSCOPY	51.01		203,322	0		22.00
23.00	ANESTHESIOLOGY	53.00		526,706	0		23.00
24.00	RADIOLOGY-DIAGNOSTIC	54.00		1,088,681	0		24.00
25.00	RADIOLOGY-THERAPEUTIC	55.00		667,738	0		25.00
26.00	LABORATORY	60.00		528,371	0		26.00
27.00	RESPIRATORY THERAPY	65.00		786,556	0		27.00
28.00	PHYSICAL THERAPY	66.00		1,287,037	0		28.00
29.00	ELECTROCARDIOLOGY	69.00		963,045	0		29.00
30.00	NEURODIAGNOSTICS	70.01		181,284	0		30.00
31.00	ASC (NON-DISTINCT PART)	75.00		357,631	0		31.00
32.00	INPATIENT DIALYSIS	76.01		17,105	0		32.00
33.00	FAMILY PRACTICE 120	88.00		444,402	0		33.00
34.00	CLINIC	90.00		28,709	0		34.00
35.00	WOUND CLINIC	90.01		84,062	0		35.00
36.00	EMERGENCY	91.00		933,255	0		36.00
37.00	DURABLE MEDICAL EQUIP-RENTED	96.00		18,497	0		37.00
38.00	HOSPICE	116.00		156,850	0		38.00
39.00	PHYSICIANS' PRIVATE OFFICES	192.00		3,062,725	0		39.00
40.00	FP PETERSBURG	192.01		23,708	0		40.00
41.00	PEDIATRICS	192.02		296,727	0		41.00
42.00	WASHINGTON PRIMARY CARE	192.03		310,985	0		42.00
43.00	FQHC	192.04		282,492	0		43.00

RECLASSIFICATIONS

Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 4/11/2024 3:17 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
44.00	COMMUNITY HEALTH SERVICES	194.00		20,454	0		44.00
45.00	CCBHC GRANTS	194.01		301,143	0		45.00
46.00	MARKETING AND PUBLIC RELATIONS	194.02		59,377	0		46.00
47.00	MH RESIDENTIAL	194.03		64,279	0		47.00
48.00	MOB	194.05		47	0		48.00
49.00	COMMUNITY MENTAL HEALTH CENTER	194.09		762,972	0		49.00
	0		0	26,017,558			
	D - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	5,029,545	11		1.00
	0		0	5,029,545			
	E - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	532,583	12		1.00
	0		0	532,583			
	F - DIETARY RECLASS						
1.00	DIETARY	10.00	1,401,049	1,060,317	0		1.00
	0		1,401,049	1,060,317			
	G - OB RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	446,812	50,213	0		1.00
2.00		0.00	0	0	0		2.00
	0		446,812	50,213			
	H - RESIDENT RECLASS						
1.00	COMMUNITY MENTAL HEALTH CENTER	194.09	0	19,182	0		1.00
	0		0	19,182			
	I - RHC RECLASS						
1.00	FAMILY PRACTICE 120	88.00	1,572,092	177,955	0		1.00
	TOTALS		1,572,092	177,955			
500.00	Grand Total: Decreases		3,419,953	60,735,275			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 4/11/2024 3:17 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,581,448	0	0	0	0	1.00
2.00	Land Improvements	10,726,598	128,122	0	128,122	0	2.00
3.00	Buildings and Fixtures	173,358,126	4,588,431	0	4,588,431	0	3.00
4.00	Building Improvements	515,426	0	0	0	36,239	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	229,887,189	0	0	0	97,334	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	421,068,787	4,716,553	0	4,716,553	133,573	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	421,068,787	4,716,553	0	4,716,553	133,573	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	6,581,448	0	1.00
2.00	Land Improvements	10,854,720	0	2.00
3.00	Buildings and Fixtures	177,946,557	0	3.00
4.00	Building Improvements	479,187	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	229,789,855	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	425,651,767	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	425,651,767	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 4/11/2024 3:17 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	16,347,994	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	40,088	0	0	2.00
3.00	Total (sum of lines 1-2)	16,347,994	0	40,088	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	16,347,994	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	40,088	2.00
3.00	Total (sum of lines 1-2)	0	16,388,082	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet A-7 Part III Date/Time Prepared: 4/11/2024 3:17 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	195,861,912	0	195,861,912	0.460146	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	229,789,855	0	229,789,855	0.539854	0	2.00
3.00	Total (sum of lines 1-2)	425,651,767	0	425,651,767	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	16,347,994	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	16,347,994	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	3,425,920	532,583	0	0	20,306,497	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	40,088	0	0	0	40,088	2.00
3.00	Total (sum of lines 1-2)	3,466,008	532,583	0	0	20,346,585	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 4/11/2024 3:17 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,603,625	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-239,303	PURCHASING & RECEIVING	4.02	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)	B	-28,004	OPERATION OF PLANT	7.00	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	-21,812,842			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-407,651	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-395,348	DRUGS CHARGED TO PATIENTS	73.00	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
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
19.02	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.02
19.03	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.03
20.00	Vending machines	B	-35,503	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00

	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	
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-610	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	MISC INCOME	B	-153,639	PURCHASING & RECEIVING	4.02	0	33.01
33.02	MISC INCOME	B	-1,758	PATIENT ACCOUNTS	4.04	0	33.02
33.03	MISC INCOME	B	-1,474,459	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MISC INCOME	B	-15,677	OPERATION OF PLANT	7.00	0	33.04
33.05	MISC INCOME	B	-33,311	HOUSEKEEPING	9.00	0	33.05
33.06	MISC INCOME	B	-219,219	PHARMACY	15.00	0	33.06
33.07	MISC INCOME	B	-42,954	MEDICAL RECORDS & LIBRARY	16.00	0	33.07
33.09	MISC INCOME	B	-2,000	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	33.09
33.10	MISC INCOME	B	-18,819	PARAMED ED PRGM-LAB	23.01	0	33.10
33.11	MISC INCOME	B	-45	SUBPROVIDER - IPF	40.00	0	33.11
33.12	MISC INCOME	B	-9,447	OPERATING ROOM	50.00	0	33.12
33.13	MISC INCOME	B	-504,722	RADIOLOGY-DIAGNOSTIC	54.00	0	33.13
33.14	MISC INCOME	B	-22,821	LABORATORY	60.00	0	33.14
33.15	MISC INCOME	B	-1,271	RESPIRATORY THERAPY	65.00	0	33.15
33.16	MISC INCOME	B	-35,449	PHYSICAL THERAPY	66.00	0	33.16
33.17	MISC INCOME	B	-96,027	ELECTROCARDIOLOGY	69.00	0	33.17
33.18	MISC INCOME	B	-17,500	WOUND CLINIC	90.01	0	33.18
33.19	ADVERTISING	A	-2,636	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	ADVERTISING	A	-19,215	MENTAL HEALTH OH	17.01	0	33.20
33.21	ADVERTISING	A	-146	SUBPROVIDER - IRF	41.00	0	33.21
33.22	ADVERTISING	A	-239	RADIOLOGY-DIAGNOSTIC	54.00	0	33.22
33.23	ADVERTISING	A	-126	PHYSICAL THERAPY	66.00	0	33.23
33.24	ADVERTISING	A	-3,487	ELECTROCARDIOLOGY	69.00	0	33.24
33.25	PHYSICIAN BILLING COSTS	A	-175,266	PATIENT ACCOUNTS	4.04	0	33.25
33.26	2012 BOND ISSUE COSTS	A	45,855	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	GME CONSORTIUM FEES	A	200,000	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	33.27
33.28	AHA LOBBYING OFFSET	A	-10,157	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	IHA LOBBYING OFFSET	A	-7,282	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	INDIANA CHAMBER LOBBYING OFFSET	A	-196	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	IHRA LOBBYING OFFSET	A	-1,000	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32	PROVIDER ASSESSMENT FEE	A	-12,796,585	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	RENTAL	A	-539,823	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	RENTAL	A	-19,620	OPERATING ROOM	50.00	0	33.34
33.35	RENTAL	A	-3,300	ELECTROCARDIOLOGY	69.00	0	33.35
33.36	RENTAL	A	-208,995	INPATIENT DIALYSIS	76.01	0	33.36
33.37	PHYSICIAN LOAN EXPENSE	A	-267,758	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38	PHYSICIAN LOAN EXPENSE	A	-30,000	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	33.38
33.39	PHYSICIAN LOAN EXPENSE	A	-50,000	OPERATING ROOM	50.00	0	33.39
33.40	PHYSICIAN LOAN EXPENSE	A	-25,353	RADIOLOGY-THERAPEUTIC	55.00	0	33.40
33.41	PHYSICIAN LOAN EXPENSE	B	-65,000	ANESTHESIOLOGY	53.00	0	33.41
33.42	PHYSICIAN LOAN EXPENSE	B	-20,000	NEURODIAGNOSTICS	70.01	0	33.42
33.43	OTHER MISC FEES	B	-790,746	CAFETERIA	11.00	0	33.43
33.44	DONATIONS EXPENSE	B	-63,924	ADMINISTRATIVE & GENERAL	5.00	0	33.44
33.45	TELEPHONE OFFSET	A	-114,387	COMMUNICATIONS	4.01	0	33.45
33.46	340B OFFSET	B	-41,978	PHARMACY	15.00	0	33.46
33.47	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.47

ADJUSTMENTS TO EXPENSES	Provider CCN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8 Date/Time Prepared: 4/11/2024 3:17 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-42,183,368				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 Date/Time Prepared: 4/11/2024 3:17 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	261,771	17,771	244,000	211,500	2,193	1.00
2.00	13.00	NURSING ADMINISTRATION	177,435	177,435	0	211,500	0	2.00
3.00	15.00	PHARMACY	18,969	0	18,969	211,500	177	3.00
4.00	16.00	MEDICAL RECORDS & LIBRARY	85,827	63,327	22,500	211,500	150	4.00
5.00	30.00	ADULTS & PEDIATRICS	3,668,633	3,668,633	0	211,500	0	5.00
6.00	50.00	OPERATING ROOM	1,627,263	1,619,763	7,500	246,400	50	6.00
7.00	53.00	ANESTHESIOLOGY	3,724,393	3,724,393	0	246,400	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	892,984	892,984	0	271,900	0	8.00
9.00	55.00	RADIOLOGY-THERAPEUTIC	2,417,310	2,368,035	49,275	271,900	219	9.00
10.00	60.00	LABORATORY	444,766	312,766	132,000	260,300	365	10.00
11.00	65.00	RESPIRATORY THERAPY	1,808,949	1,785,549	23,400	211,500	247	11.00
12.00	66.00	PHYSICAL THERAPY	1,831,817	1,831,817	0	211,500	0	12.00
13.00	69.00	ELECTROCARDIOLOGY	3,093,168	3,083,168	10,000	211,500	90	13.00
14.00	70.01	NEURODIAGNOSTICS	795,954	779,454	16,500	211,500	96	14.00
15.00	75.00	ASC (NON-DISTINCT PART)	103,850	68,750	35,100	211,500	276	15.00
16.00	76.01	INPATIENT DIALYSIS	40,560	0	40,560	211,500	637	16.00
17.00	91.00	EMERGENCY	1,274,225	1,235,225	39,000	211,500	75	17.00
200.00			22,267,874	21,629,070	638,804		4,575	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	222,990	11,150	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	15.00	PHARMACY	17,998	900	0	0	0	3.00
4.00	16.00	MEDICAL RECORDS & LIBRARY	15,252	763	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	5,923	296	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	8.00
9.00	55.00	RADIOLOGY-THERAPEUTIC	28,628	1,431	0	0	0	9.00
10.00	60.00	LABORATORY	45,678	2,284	0	0	0	10.00
11.00	65.00	RESPIRATORY THERAPY	25,116	1,256	0	0	0	11.00
12.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	12.00
13.00	69.00	ELECTROCARDIOLOGY	9,151	458	0	0	0	13.00
14.00	70.01	NEURODIAGNOSTICS	9,762	488	0	0	0	14.00
15.00	75.00	ASC (NON-DISTINCT PART)	28,064	1,403	0	0	0	15.00
16.00	76.01	INPATIENT DIALYSIS	64,772	3,239	0	0	0	16.00
17.00	91.00	EMERGENCY	7,626	381	0	0	0	17.00
200.00			480,960	24,049	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	222,990	21,010	38,781		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	177,435		2.00
3.00	15.00	PHARMACY	0	17,998	971	971		3.00
4.00	16.00	MEDICAL RECORDS & LIBRARY	0	15,252	7,248	70,575		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	3,668,633		5.00
6.00	50.00	OPERATING ROOM	0	5,923	1,577	1,621,340		6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	3,724,393		7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	892,984		8.00
9.00	55.00	RADIOLOGY-THERAPEUTIC	0	28,628	20,647	2,388,682		9.00
10.00	60.00	LABORATORY	0	45,678	86,322	399,088		10.00
11.00	65.00	RESPIRATORY THERAPY	0	25,116	0	1,785,549		11.00
12.00	66.00	PHYSICAL THERAPY	0	0	0	1,831,817		12.00
13.00	69.00	ELECTROCARDIOLOGY	0	9,151	849	3,084,017		13.00
14.00	70.01	NEURODIAGNOSTICS	0	9,762	6,738	786,192		14.00
15.00	75.00	ASC (NON-DISTINCT PART)	0	28,064	7,036	75,786		15.00
16.00	76.01	INPATIENT DIALYSIS	0	64,772	0	0		16.00
17.00	91.00	EMERGENCY	0	7,626	31,374	1,266,599		17.00
200.00			0	480,960	183,772	21,812,842		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
			0	1.00	2.00	4.00	4.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	20,306,497	20,306,497				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	40,088		40,088			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	28,414,621	111,623	220	28,526,464		4.00
4.01	00401	COMMUNICATIONS	210,740	0	0	84,525	295,265	4.01
4.02	00402	PURCHASING & RECEIVING	780,178	265,741	525	198,631	2,799	4.02
4.03	00403	REGISTRATION	1,823,145	259,520	512	470,574	5,178	4.03
4.04	00404	PATIENT ACCOUNTS	3,931,598	0	0	636,330	6,297	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	19,684,607	1,101,214	2,174	2,045,405	26,308	5.00
7.00	00700	OPERATION OF PLANT	7,657,178	5,508,364	10,874	671,031	16,932	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	339,432	120,898	239	62,449	0	8.00
9.00	00900	HOUSEKEEPING	2,560,935	168,192	332	609,415	5,178	9.00
10.00	01000	DIETARY	887,887	87,769	173	131,636	980	10.00
11.00	01100	CAFETERIA	1,227,466	199,645	394	364,917	2,799	11.00
13.00	01300	NURSING ADMINISTRATION	4,313,563	224,141	442	594,959	2,659	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	600,644	91,075	180	100,594	980	14.00
15.00	01500	PHARMACY	3,316,672	137,267	271	834,046	4,478	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,490,681	105,149	208	1,051,882	6,577	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	565,640	59,806	118	89,987	12,314	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	3,634,739	232,888	460	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,846,164	0	0	521,542	4,758	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	272,706	0	0	72,452	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,106,392	1,040,650	2,054	1,884,316	28,547	30.00
31.00	03100	INTENSIVE CARE UNIT	4,530,856	481,066	950	906,227	13,434	31.00
40.00	04000	SUBPROVIDER - IPF	2,835,093	299,237	591	582,439	0	40.00
41.00	04100	SUBPROVIDER - IRF	2,280,009	394,721	779	519,225	10,355	41.00
43.00	04300	NURSERY	309,790	239,546	473	72,536	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,165,994	551,594	1,089	861,690	20,571	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	1,613,096	280,940	555	220,225	3,638	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	187,235	144,775	286	43,840	3,219	52.00
53.00	05300	ANESTHESIOLOGY	656,891	0	0	745,344	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,595,219	497,413	982	1,292,320	13,294	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,090,647	412,904	815	765,051	5,178	55.00
60.00	06000	LABORATORY	7,504,290	167,549	331	635,838	4,758	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,407,470	130,380	257	709,544	5,458	65.00
66.00	06600	PHYSICAL THERAPY	4,162,063	650,774	1,285	1,507,623	8,676	66.00
69.00	06900	ELECTROCARDIOLOGY	2,994,538	417,403	824	1,329,457	11,335	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	1,039,924	176,962	349	231,726	2,799	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,675,266	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,249,606	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,527,702	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	2,038,635	0	0	318,025	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	248,408	197,027	389	24,351	280	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	24,307	0	0	5,687	0	88.00
90.00	09000	CLINIC	158,831	51,748	102	41,043	1,399	90.00
90.01	04950	WOUND CLINIC	992,844	68,324	135	97,016	1,399	90.01
91.00	09100	EMERGENCY	5,776,408	543,398	1,073	1,224,888	14,134	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	158,620	9,046	18	24,761	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	881,815	111,600	220	134,317	3,219	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	201,117,130	15,540,349	30,679	22,717,864	249,930	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,871,575	2,619,073	5,170	3,914,210	40,716	192.00
192.01	19201	FP PETERSBURG	255,423	85,060	168	33,940	0	192.01
192.02	19202	PEDIATRICS	1,200,013	0	0	239,731	2,799	192.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4.01	
192.03	19203	WASHINGTON PRIMARY CARE	1,647,384	156,116	308	371,547	0	192.03
192.04	19204	FQHC	-72	0	0	0	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	132,184	9,528	19	30,745	560	194.00
194.01	07960	CCBHC GRANTS	1,985,947	0	0	263,470	0	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	764,095	38,799	77	67,806	840	194.02
194.03	07953	MH RESIDENTIAL	298,437	465,133	918	71,394	0	194.03
194.04	07954	UNUSED SPACE	0	467,659	923	0	0	194.04
194.05	07955	MOB	36,658	0	0	42	0	194.05
194.06	07956	FOUNDATION	0	10,699	21	0	420	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	108,179	214	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	3,475,145	805,902	1,591	815,715	0	194.09
194.10	07951	BEIRHAUS BUILDING	116,137	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	230,900,056	20,306,497	40,088	28,526,464	295,265	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	Subtotal	ADMINISTRATIVE & GENERAL	
			4.02	4.03	4.04	4A.04	5.00	
		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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING	1,247,874					4.02
4.03	00403	REGISTRATION	521	2,559,450				4.03
4.04	00404	PATIENT ACCOUNTS	617	0	4,574,842			4.04
5.00	00500	ADMINISTRATIVE & GENERAL	6,187	0	0	22,865,895	22,865,895	5.00
7.00	00700	OPERATION OF PLANT	12,790	0	0	13,877,169	1,525,295	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,989	0	0	528,007	58,035	8.00
9.00	00900	HOUSEKEEPING	13,377	0	0	3,357,429	369,028	9.00
10.00	01000	DIETARY	24,202	0	0	1,132,647	124,494	10.00
11.00	01100	CAFETERIA	67,092	0	0	1,862,313	204,694	11.00
13.00	01300	NURSING ADMINISTRATION	274	0	0	5,136,038	564,522	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,845	0	0	800,318	87,966	14.00
15.00	01500	PHARMACY	1,710	0	0	4,294,444	472,020	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	377	0	0	5,654,874	621,550	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	139	0	0	728,004	80,018	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	3,868,087	425,157	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	3,638	0	0	3,376,102	371,081	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	177	0	0	345,335	37,957	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,274	126,415	225,958	13,444,606	1,477,750	30.00
31.00	03100	INTENSIVE CARE UNIT	21,317	49,033	87,644	6,090,527	669,434	31.00
40.00	04000	SUBPROVIDER - IPF	1,662	36,648	65,506	3,821,176	420,001	40.00
41.00	04100	SUBPROVIDER - IRF	5,640	31,245	55,849	3,297,823	362,477	41.00
43.00	04300	NURSERY	0	4,917	8,788	636,050	69,911	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	52,379	174,128	311,243	6,138,688	674,728	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	38,805	52,527	93,889	2,303,675	253,206	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,424	8,135	14,541	405,455	44,565	52.00
53.00	05300	ANESTHESIOLOGY	0	32,319	57,767	1,492,321	164,027	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,862	451,717	807,409	10,709,216	1,177,093	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,327	108,350	193,668	4,582,940	503,729	55.00
60.00	06000	LABORATORY	89,563	322,779	576,945	9,302,053	1,022,426	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	998	48,681	87,014	3,389,802	372,587	65.00
66.00	06600	PHYSICAL THERAPY	3,133	104,298	186,426	6,624,278	728,101	66.00
69.00	06900	ELECTROCARDIOLOGY	14,423	174,753	312,359	5,255,092	577,608	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	2,863	24,941	44,581	1,524,145	167,525	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	410,668	13,104	23,422	4,122,460	453,116	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	258,720	50,415	90,114	4,648,855	510,974	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	368,779	659,167	20,555,648	2,259,353	73.00
75.00	07500	ASC (NON-DISTINCT PART)	29,734	115,011	205,575	2,706,980	297,535	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	173	3,985	7,123	481,736	52,950	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	0	184	329	30,507	3,353	88.00
90.00	09000	CLINIC	18	493	881	254,515	27,975	90.00
90.01	04950	WOUND CLINIC	8,639	21,199	37,892	1,227,448	134,914	90.01
91.00	09100	EMERGENCY	24,160	227,108	405,941	8,217,110	903,175	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	371	1,797	3,212	197,825	21,744	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	881	6,489	11,599	1,150,140	126,416	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,197,969	2,559,450	4,574,842	190,437,733	18,418,490	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	40,020	0	0	26,490,764	2,911,728	192.00
192.01	19201	FP PETERSBURG	119	0	0	374,710	41,186	192.01
192.02	19202	PEDIATRICS	2,598	0	0	1,445,141	158,841	192.02
192.03	19203	WASHINGTON PRIMARY CARE	2,022	0	0	2,177,377	239,324	192.03
192.04	19204	FQHC	0	0	0	-72	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	80	0	0	173,116	19,028	194.00
194.01	07960	CCBHC GRANTS	1,364	0	0	2,250,781	247,392	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	29	0	0	871,646	95,806	194.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	Subtotal	ADMINISTRATIVE & GENERAL	
			4.02	4.03	4.04	4A.04	5.00	
194.03	07953	MH RESIDENTIAL	992	0	0	836,874	91,984	194.03
194.04	07954	UNUSED SPACE	0	0	0	468,582	51,504	194.04
194.05	07955	MOB	0	0	0	36,700	4,034	194.05
194.06	07956	FOUNDATION	0	0	0	11,140	1,224	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	108,393	11,914	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	2,652	0	0	5,101,005	560,672	194.09
194.10	07951	BEIRHAUS BUILDING	29	0	0	116,166	12,768	194.10
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,247,874	2,559,450	4,574,842	230,900,056	22,865,895	202.00

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	15,402,464					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	142,582	728,624				8.00
9.00	00900	HOUSEKEEPING	198,359	30,670	3,955,486			9.00
10.00	01000	DIETARY	103,511	2,480	97,824	1,460,956		10.00
11.00	01100	CAFETERIA	235,453	6,875	23,080	0	2,332,415	11.00
13.00	01300	NURSING ADMINISTRATION	264,343	0	0	0	59,337	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	107,410	12,155	42,847	0	17,946	14.00
15.00	01500	PHARMACY	161,887	0	33,862	0	78,011	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	124,008	0	34,592	0	139,441	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	70,533	0	105,574	0	8,049	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	274,659	0	0	0	71	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	80,584	0	40,489	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	0	7,705	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,227,300	220,726	648,775	683,890	170,896	30.00
31.00	03100	INTENSIVE CARE UNIT	567,350	38,978	228,669	243,013	100,970	31.00
40.00	04000	SUBPROVIDER - IPF	352,908	12,826	0	218,318	66,959	40.00
41.00	04100	SUBPROVIDER - IRF	465,517	35,354	171,502	315,735	68,992	41.00
43.00	04300	NURSERY	282,511	50,807	149,320	0	39,338	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	650,527	28,183	167,514	0	77,455	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	331,329	16,704	57,167	0	28,214	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	170,741	30,707	90,243	0	23,776	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	16,958	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	586,628	43,532	113,941	0	125,748	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	486,961	6,842	65,759	0	68,298	55.00
60.00	06000	LABORATORY	197,600	0	53,012	0	108,845	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	153,764	1,597	37,849	0	71,636	65.00
66.00	06600	PHYSICAL THERAPY	767,495	13,900	164,594	0	145,136	66.00
69.00	06900	ELECTROCARDIOLOGY	492,268	15,807	182,789	0	93,855	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	208,702	7,839	51,552	0	23,210	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	25,508	161,674	0	43,309	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	232,366	0	0	0	1,916	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	0	0	0	0	0	88.00
90.00	09000	CLINIC	61,029	48	62,671	0	4,869	90.00
90.01	04950	WOUND CLINIC	80,578	11,299	19,542	0	11,890	90.01
91.00	09100	EMERGENCY	640,861	88,430	236,531	0	137,731	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	10,668	0	0	0	3,547	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	131,616	0	66,321	0	18,975	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,781,464	701,267	3,147,788	1,460,956	1,803,572	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,088,828	27,357	730,763	0	349,527	192.00
192.01	19201	FP PETERSBURG	100,316	0	0	0	5,210	192.01
192.02	19202	PEDIATRICS	0	0	0	0	24,578	192.02
192.03	19203	WASHINGTON PRIMARY CARE	184,117	0	0	0	35,514	192.03
192.04	19204	FQHC	0	0	15,836	0	33,248	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	11,237	0	0	0	3,136	194.00
194.01	07960	CCBHC GRANTS	0	0	3,089	0	53,138	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	45,758	0	0	0	8,610	194.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
194.03	07953	MH RESIDENTIAL	548,559	0	0	0	15,882	194.03
194.04	07954	UNUSED SPACE	551,538	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	12,617	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	127,582	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	950,448	0	0	0	0	194.09
194.10	07951	BEIRHAUS BUILDING	0	0	58,010	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	15,402,464	728,624	3,955,486	1,460,956	2,332,415	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
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	6,024,240					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,068,642				14.00
15.00	01500	PHARMACY	0	1,645	5,041,869			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	362	0	6,574,827		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	134	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	269,721	3,499	2,065	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	171	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,106,058	29,120	228	874,484	0	30.00
31.00	03100	INTENSIVE CARE UNIT	672,618	20,505	25	744,931	0	31.00
40.00	04000	SUBPROVIDER - IPF	446,055	1,598	0	817,805	0	40.00
41.00	04100	SUBPROVIDER - IRF	459,598	5,425	1,901	526,310	0	41.00
43.00	04300	NURSERY	254,592	0	52	64,777	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	395,857	50,383	3,655	275,301	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	187,947	37,326	145	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	153,873	3,293	32	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	86,338	48,924	113,680	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	304,109	6,086	1,480	0	0	55.00
60.00	06000	LABORATORY	0	86,150	11	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	960	488	0	0	65.00
66.00	06600	PHYSICAL THERAPY	247,947	3,014	19,909	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	13,873	354	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	22,454	2,754	8	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	395,017	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	248,861	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,563,323	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	288,509	28,601	3,648	1,781,357	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	12,765	166	540	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	18	0	0	0	90.00
90.01	04950	WOUND CLINIC	18,698	8,310	3,993	194,330	0	90.01
91.00	09100	EMERGENCY	917,505	23,239	2,784	1,295,532	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	357	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	126,405	847	6	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,971,049	1,020,638	4,718,327	6,574,827	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	53,191	38,495	258,358	0	0	192.00
192.01	19201	FP PETERSBURG	0	115	1,134	0	0	192.01
192.02	19202	PEDIATRICS	0	2,499	45,159	0	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	1,945	18,803	0	0	192.03
192.04	19204	FQHC	0	0	0	0	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	77	88	0	0	194.00
194.01	07960	CCBHC GRANTS	0	1,312	0	0	0	194.01

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	28	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	0	954	0	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	2,551	0	0	0	194.09
194.10	07951	BEIRHAUS BUILDING	0	28	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,024,240	1,068,642	5,041,869	6,574,827	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	MENTAL HEALTH OH	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LAB	
			17.01	21.00	22.00	23.00	23.01	
		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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
17.01	01701	MENTAL HEALTH OH	992,312					17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	4,567,974				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		4,143,541			22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0			0		23.00
23.01	02301	PARAMED ED PRGM-LAB	0				391,168	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	883,453	801,367	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	34,299	31,112	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	670,285	334,673	303,577	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	156,943	142,361	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	14,551	13,199	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,315	7,542	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	48,850	44,311	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	391,168	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	39,496	35,826	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	32,220	29,226	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	64,440	58,453	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	1,149,528	1,042,720	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0			0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	670,285	2,766,768	2,509,694	0	391,168	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	730,668	662,778	0	0	192.00
192.01	19201	FP PETERSBURG	0	0	0	0	0	192.01
192.02	19202	PEDIATRICS	0	0	0	0	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	0	0	0	0	192.03
192.04	19204	FQHC	0	0	0	0	0	192.04

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	MENTAL HEALTH OH	INTERNS & RESIDENTS		PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LAB	
				SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
			17.01	21.00	22.00	23.00	23.01	
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	0	0	194.00
194.01	07960	CCBHC GRANTS	0	0	0	0	0	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	0	0	0	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	322,027	1,070,538	971,069	0	0	194.09
194.10	07951	BEIRHAUS BUILDING	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	992,312	4,567,974	4,143,541	0	391,168	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
4.01	00401	COMMUNICATIONS				4.01
4.02	00402	PURCHASING & RECEIVING				4.02
4.03	00403	REGISTRATION				4.03
4.04	00404	PATIENT ACCOUNTS				4.04
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
17.01	01701	MENTAL HEALTH OH				17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY				23.00
23.01	02301	PARAMED ED PRGM-LAB				23.01
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	21,568,653	-1,684,820	19,883,833	30.00
31.00	03100	INTENSIVE CARE UNIT	9,442,431	-65,411	9,377,020	31.00
40.00	04000	SUBPROVIDER - IPF	7,466,181	-638,250	6,827,931	40.00
41.00	04100	SUBPROVIDER - IRF	5,710,634	0	5,710,634	41.00
43.00	04300	NURSERY	1,547,358	0	1,547,358	43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	8,462,291	0	8,462,291	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
51.01	05101	ENDOSCOPY	3,515,017	-299,304	3,215,713	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	922,685	0	922,685	52.00
53.00	05300	ANESTHESIOLOGY	1,701,056	-27,750	1,673,306	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,020,957	-15,857	13,005,100	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,119,365	-93,161	6,026,204	55.00
60.00	06000	LABORATORY	11,161,265	0	11,161,265	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	4,104,005	-75,322	4,028,683	65.00
66.00	06600	PHYSICAL THERAPY	8,714,374	0	8,714,374	66.00
69.00	06900	ELECTROCARDIOLOGY	6,693,092	-61,446	6,631,646	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	2,008,189	0	2,008,189	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,970,593	0	4,970,593	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,408,690	0	5,408,690	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,378,324	0	27,378,324	73.00
75.00	07500	ASC (NON-DISTINCT PART)	5,337,121	0	5,337,121	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	905,332	-122,893	782,439	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	FAMILY PRACTICE 120	33,860	0	33,860	88.00
90.00	09000	CLINIC	411,125	0	411,125	90.00
90.01	04950	WOUND CLINIC	1,711,002	0	1,711,002	90.01
91.00	09100	EMERGENCY	14,655,146	-2,192,248	12,462,898	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	234,141	0	234,141	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	1,620,726	0	1,620,726	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	174,823,613	-5,276,462	169,547,151	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	35,342,457	-1,393,446	33,949,011	192.00
192.01	19201	FP PETERSBURG	522,671	0	522,671	192.01
192.02	19202	PEDIATRICS	1,676,218	0	1,676,218	192.02
192.03	19203	WASHINGTON PRIMARY CARE	2,657,080	0	2,657,080	192.03
192.04	19204	FQHC	49,012	0	49,012	192.04

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
194.00	07950	COMMUNITY HEALTH SERVICES	206,682	0	206,682	194.00
194.01	07960	CCBHC GRANTS	2,555,712	0	2,555,712	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	1,021,848	0	1,021,848	194.02
194.03	07953	MH RESIDENTIAL	1,494,253	0	1,494,253	194.03
194.04	07954	UNUSED SPACE	1,071,624	0	1,071,624	194.04
194.05	07955	MOB	40,734	0	40,734	194.05
194.06	07956	FOUNDATION	24,981	0	24,981	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	247,889	0	247,889	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	8,978,310	-2,041,607	6,936,703	194.09
194.10	07951	BEIRHAUS BUILDING	186,972	0	186,972	194.10
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	230,900,056	-8,711,515	222,188,541	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	111,623	220	111,843	111,843	4.00
4.01	00401	COMMUNICATIONS	0	0	0	0	331	4.01
4.02	00402	PURCHASING & RECEIVING	0	265,741	525	266,266	779	4.02
4.03	00403	REGISTRATION	0	259,520	512	260,032	1,845	4.03
4.04	00404	PATIENT ACCOUNTS	0	0	0	0	2,494	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,101,214	2,174	1,103,388	8,018	5.00
7.00	00700	OPERATION OF PLANT	0	5,508,364	10,874	5,519,238	2,630	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	120,898	239	121,137	245	8.00
9.00	00900	HOUSEKEEPING	0	168,192	332	168,524	2,389	9.00
10.00	01000	DIETARY	0	87,769	173	87,942	516	10.00
11.00	01100	CAFETERIA	0	199,645	394	200,039	1,430	11.00
13.00	01300	NURSING ADMINISTRATION	0	224,141	442	224,583	2,332	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	91,075	180	91,255	394	14.00
15.00	01500	PHARMACY	0	137,267	271	137,538	3,269	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	105,149	208	105,357	4,123	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	59,806	118	59,924	353	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	232,888	460	233,348	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	2,044	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	0	284	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,040,650	2,054	1,042,704	7,386	30.00
31.00	03100	INTENSIVE CARE UNIT	0	481,066	950	482,016	3,552	31.00
40.00	04000	SUBPROVIDER - IPF	0	299,237	591	299,828	2,283	40.00
41.00	04100	SUBPROVIDER - IRF	0	394,721	779	395,500	2,035	41.00
43.00	04300	NURSERY	0	239,546	473	240,019	284	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	551,594	1,089	552,683	3,378	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	280,940	555	281,495	863	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	144,775	286	145,061	172	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	2,922	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	497,413	982	498,395	5,066	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	412,904	815	413,719	2,999	55.00
60.00	06000	LABORATORY	0	167,549	331	167,880	2,492	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	130,380	257	130,637	2,781	65.00
66.00	06600	PHYSICAL THERAPY	0	650,774	1,285	652,059	5,910	66.00
69.00	06900	ELECTROCARDIOLOGY	0	417,403	824	418,227	5,211	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	176,962	349	177,311	908	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	1,247	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	197,027	389	197,416	95	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	0	0	0	0	22	88.00
90.00	09000	CLINIC	0	51,748	102	51,850	161	90.00
90.01	04950	WOUND CLINIC	0	68,324	135	68,459	380	90.01
91.00	09100	EMERGENCY	0	543,398	1,073	544,471	4,802	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	9,046	18	9,064	97	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	111,600	220	111,820	527	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	15,540,349	30,679	15,571,028	89,049	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,619,073	5,170	2,624,243	15,367	192.00
192.01	19201	FP PETERSBURG	0	85,060	168	85,228	133	192.01
192.02	19202	PEDIATRICS	0	0	0	0	940	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	156,116	308	156,424	1,456	192.03

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		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
192.04	19204	FQHC	0	0	0	0	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	9,528	19	9,547	121	194.00
194.01	07960	CCBHC GRANTS	0	0	0	0	1,033	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	38,799	77	38,876	266	194.02
194.03	07953	MH RESIDENTIAL	0	465,133	918	466,051	280	194.03
194.04	07954	UNUSED SPACE	0	467,659	923	468,582	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	10,699	21	10,720	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	108,179	214	108,393	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	805,902	1,591	807,493	3,198	194.09
194.10	07951	BEIRHAUS BUILDING	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	20,306,497	40,088	20,346,585	111,843	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	COMMUNICATIONS	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	ADMINISTRATIVE & GENERAL	
			4.01	4.02	4.03	4.04	5.00	
		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
4.01	00401	COMMUNICATIONS	331					4.01
4.02	00402	PURCHASING & RECEIVING	3	267,048				4.02
4.03	00403	REGISTRATION	6	112	261,995			4.03
4.04	00404	PATIENT ACCOUNTS	7	132	0	2,633		4.04
5.00	00500	ADMINISTRATIVE & GENERAL	29	1,324	0	0	1,112,759	5.00
7.00	00700	OPERATION OF PLANT	19	2,737	0	0	74,229	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,068	0	0	2,824	8.00
9.00	00900	HOUSEKEEPING	6	2,863	0	0	17,959	9.00
10.00	01000	DIETARY	1	5,179	0	0	6,059	10.00
11.00	01100	CAFETERIA	3	14,357	0	0	9,962	11.00
13.00	01300	NURSING ADMINISTRATION	3	59	0	0	27,473	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1	1,465	0	0	4,281	14.00
15.00	01500	PHARMACY	5	366	0	0	22,971	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7	81	0	0	30,248	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	14	30	0	0	3,894	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	20,690	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	5	778	0	0	18,059	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	38	0	0	1,847	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32	6,478	12,939	128	71,915	30.00
31.00	03100	INTENSIVE CARE UNIT	15	4,562	5,019	50	32,578	31.00
40.00	04000	SUBPROVIDER - IPF	0	356	3,751	37	20,439	40.00
41.00	04100	SUBPROVIDER - IRF	12	1,207	3,198	32	17,640	41.00
43.00	04300	NURSERY	0	0	503	5	3,402	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23	11,209	17,823	176	32,836	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	4	8,304	5,376	53	12,322	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	4	733	833	8	2,169	52.00
53.00	05300	ANESTHESIOLOGY	0	0	3,308	33	7,982	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15	10,884	46,257	498	57,284	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6	1,354	11,090	110	24,514	55.00
60.00	06000	LABORATORY	5	19,166	33,038	327	49,757	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	6	214	4,983	49	18,132	65.00
66.00	06600	PHYSICAL THERAPY	10	670	10,676	106	35,433	66.00
69.00	06900	ELECTROCARDIOLOGY	13	3,086	17,887	177	28,109	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	3	613	2,553	25	8,153	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	87,889	1,341	13	22,051	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	55,365	5,160	51	24,867	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	37,747	374	109,952	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	6,363	11,772	117	14,480	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	37	408	4	2,577	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	0	0	19	0	163	88.00
90.00	09000	CLINIC	2	4	50	0	1,361	90.00
90.01	04950	WOUND CLINIC	2	1,849	2,170	21	6,566	90.01
91.00	09100	EMERGENCY	16	5,170	23,246	230	43,953	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	79	184	2	1,058	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	4	188	664	7	6,152	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	281	256,369	261,995	2,633	896,341	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	45	8,564	0	0	141,686	192.00
192.01	19201	FP PETERSBURG	0	25	0	0	2,004	192.01
192.02	19202	PEDIATRICS	3	556	0	0	7,730	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	433	0	0	11,647	192.03
192.04	19204	FQHC	0	0	0	0	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	1	17	0	0	926	194.00
194.01	07960	CCBHC GRANTS	0	292	0	0	12,039	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	1	6	0	0	4,662	194.02

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		Cost Center Description	COMMUNICATIONS	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	ADMINISTRATIVE & GENERAL	
			4.01	4.02	4.03	4.04	5.00	
194.03	07953	MH RESIDENTIAL	0	212	0	0	4,476	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	2,506	194.04
194.05	07955	MOB	0	0	0	0	196	194.05
194.06	07956	FOUNDATION	0	0	0	0	60	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	580	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	568	0	0	27,285	194.09
194.10	07951	BEIRHAUS BUILDING	0	6	0	0	621	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	331	267,048	261,995	2,633	1,112,759	202.00

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		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	5,598,853					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	51,829	177,103				8.00
9.00	00900	HOUSEKEEPING	72,104	7,455	271,300			9.00
10.00	01000	DIETARY	37,627	603	6,710	144,637		10.00
11.00	01100	CAFETERIA	85,588	1,671	1,583	0	314,633	11.00
13.00	01300	NURSING ADMINISTRATION	96,090	0	0	0	8,004	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	39,044	2,954	2,939	0	2,421	14.00
15.00	01500	PHARMACY	58,847	0	2,323	0	10,523	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	45,077	0	2,373	0	18,810	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	25,639	0	7,241	0	1,086	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	99,839	0	0	0	10	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	5,527	0	5,462	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	0	1,039	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	446,128	53,652	44,498	67,706	23,053	30.00
31.00	03100	INTENSIVE CARE UNIT	206,234	9,474	15,684	24,059	13,620	31.00
40.00	04000	SUBPROVIDER - IPF	128,283	3,118	0	21,614	9,033	40.00
41.00	04100	SUBPROVIDER - IRF	169,217	8,593	11,763	31,258	9,307	41.00
43.00	04300	NURSERY	102,694	12,349	10,242	0	5,306	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	236,469	6,850	11,490	0	10,448	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	120,439	4,060	3,921	0	3,806	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	62,065	7,464	6,190	0	3,207	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	2,288	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	213,241	10,581	7,815	0	16,963	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	177,012	1,663	4,510	0	9,213	55.00
60.00	06000	LABORATORY	71,828	0	3,636	0	14,683	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	55,894	388	2,596	0	9,663	65.00
66.00	06600	PHYSICAL THERAPY	278,987	3,379	11,289	0	19,578	66.00
69.00	06900	ELECTROCARDIOLOGY	178,941	3,842	12,537	0	12,661	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	75,864	1,905	3,536	0	3,131	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	6,200	11,089	0	5,842	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	84,466	0	0	0	258	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	0	0	0	0	0	88.00
90.00	09000	CLINIC	22,184	12	4,298	0	657	90.00
90.01	04950	WOUND CLINIC	29,290	2,746	1,340	0	1,604	90.01
91.00	09100	EMERGENCY	232,955	21,494	16,223	0	18,579	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	3,878	0	0	0	478	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	47,843	0	4,549	0	2,560	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,555,596	170,453	215,902	144,637	243,293	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,122,804	6,650	50,121	0	47,151	192.00
192.01	19201	FP PETERSBURG	36,465	0	0	0	703	192.01
192.02	19202	PEDIATRICS	0	0	0	0	3,315	192.02
192.03	19203	WASHINGTON PRIMARY CARE	66,927	0	0	0	4,791	192.03
192.04	19204	FQHC	0	0	1,086	0	4,485	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	4,085	0	0	0	423	194.00
194.01	07960	CCBHC GRANTS	0	0	212	0	7,168	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	16,633	0	0	0	1,162	194.02

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		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
194.03	07953	MH RESIDENTIAL	199,403	0	0	0	2,142	194.03
194.04	07954	UNUSED SPACE	200,486	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	4,586	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	46,377	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	345,491	0	0	0	0	194.09
194.10	07951	BEIRHAUS BUILDING	0	0	3,979	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,598,853	177,103	271,300	144,637	314,633	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
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	358,544					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	144,754				14.00
15.00	01500	PHARMACY	0	223	236,065			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	49	0	206,125		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	18	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	16,053	474	97	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	23	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,829	3,945	11	27,416	0	30.00
31.00	03100	INTENSIVE CARE UNIT	40,032	2,778	1	23,354	0	31.00
40.00	04000	SUBPROVIDER - IPF	26,548	217	0	25,639	0	40.00
41.00	04100	SUBPROVIDER - IRF	27,354	735	89	16,500	0	41.00
43.00	04300	NURSERY	15,152	0	2	2,031	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,560	6,825	171	8,631	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	11,186	5,056	7	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,158	446	1	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,139	6,627	5,322	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	18,100	824	69	0	0	55.00
60.00	06000	LABORATORY	0	11,670	1	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	130	23	0	0	65.00
66.00	06600	PHYSICAL THERAPY	14,757	408	932	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,879	17	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	1,336	373	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	53,505	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	33,711	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	213,662	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	17,171	3,874	171	55,846	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	760	22	25	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	2	0	0	0	90.00
90.01	04950	WOUND CLINIC	1,113	1,126	187	6,092	0	90.01
91.00	09100	EMERGENCY	54,607	3,148	130	40,616	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	48	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	7,523	115	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	355,378	138,251	220,918	206,125	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,166	5,215	12,096	0	0	192.00
192.01	19201	FP PETERSBURG	0	16	53	0	0	192.01
192.02	19202	PEDIATRICS	0	338	2,114	0	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	263	880	0	0	192.03
192.04	19204	FQHC	0	0	0	0	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	10	4	0	0	194.00
194.01	07960	CCBHC GRANTS	0	178	0	0	0	194.01

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	4	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	0	129	0	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	346	0	0	0	194.09
194.10	07951	BEIRHAUS BUILDING	0	4	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	358,544	144,754	236,065	206,125	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	MENTAL HEALTH OH	INTERNS & RESIDENTS		PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LAB	
				SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
			17.01	21.00	22.00	23.00	23.01	
		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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
17.01	01701	MENTAL HEALTH OH	98,199					17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	353,887				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		48,499			22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0			0		23.00
23.01	02301	PARAMED ED PRGM-LAB	0				3,231	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0					30.00
31.00	03100	INTENSIVE CARE UNIT	0					31.00
40.00	04000	SUBPROVIDER - IPF	66,333					40.00
41.00	04100	SUBPROVIDER - IRF	0					41.00
43.00	04300	NURSERY	0					43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0					50.00
51.00	05100	RECOVERY ROOM	0					51.00
51.01	05101	ENDOSCOPY	0					51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0					52.00
53.00	05300	ANESTHESIOLOGY	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0					54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0					55.00
60.00	06000	LABORATORY	0					60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0					63.00
65.00	06500	RESPIRATORY THERAPY	0					65.00
66.00	06600	PHYSICAL THERAPY	0					66.00
69.00	06900	ELECTROCARDIOLOGY	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0					70.00
70.01	07001	NEURODIAGNOSTICS	0					70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0					73.00
75.00	07500	ASC (NON-DISTINCT PART)	0					75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0					76.00
76.01	03951	INPATIENT DIALYSIS	0					76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	0					88.00
90.00	09000	CLINIC	0					90.00
90.01	04950	WOUND CLINIC	0					90.01
91.00	09100	EMERGENCY	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0					96.00
101.00	10100	HOME HEALTH AGENCY	0					101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0					116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,333	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0					192.00
192.01	19201	FP PETERSBURG	0					192.01
192.02	19202	PEDIATRICS	0					192.02
192.03	19203	WASHINGTON PRIMARY CARE	0					192.03
192.04	19204	FQHC	0					192.04

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	MENTAL HEALTH OH	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LAB	
			17.01	21.00	22.00	23.00	23.01	
194.00	07950	COMMUNITY HEALTH SERVICES	0					194.00
194.01	07960	CCBHC GRANTS	0					194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0					194.02
194.03	07953	MH RESIDENTIAL	0					194.03
194.04	07954	UNUSED SPACE	0					194.04
194.05	07955	MOB	0					194.05
194.06	07956	FOUNDATION	0					194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0					194.07
194.08	07958	INDUSTRIAL HEALTH	0					194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	31,866					194.09
194.10	07951	BEIRHAUS BUILDING	0					194.10
200.00		Cross Foot Adjustments		353,887	48,499	0	3,231	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	98,199	353,887	48,499	0	3,231	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	PURCHASING & RECEIVING					4.02
4.03	00403	REGISTRATION					4.03
4.04	00404	PATIENT ACCOUNTS					4.04
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
17.01	01701	MENTAL HEALTH OH					17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD					22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY					23.00
23.01	02301	PARAMED ED PRGM-LAB					23.01
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,873,820	0	1,873,820		30.00
31.00	03100	INTENSIVE CARE UNIT	863,028	0	863,028		31.00
40.00	04000	SUBPROVIDER - IPF	607,479	0	607,479		40.00
41.00	04100	SUBPROVIDER - IRF	694,440	0	694,440		41.00
43.00	04300	NURSERY	391,989	0	391,989		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	922,572	0	922,572		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
51.01	05101	ENDOSCOPY	456,892	0	456,892		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	237,511	0	237,511		52.00
53.00	05300	ANESTHESIOLOGY	16,533	0	16,533		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	884,087	0	884,087		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	665,183	0	665,183		55.00
60.00	06000	LABORATORY	374,483	0	374,483		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	225,496	0	225,496		65.00
66.00	06600	PHYSICAL THERAPY	1,034,194	0	1,034,194		66.00
69.00	06900	ELECTROCARDIOLOGY	682,587	0	682,587		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	275,711	0	275,711		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	164,799	0	164,799		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	119,154	0	119,154		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	361,735	0	361,735		73.00
75.00	07500	ASC (NON-DISTINCT PART)	134,172	0	134,172		75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0		76.00
76.01	03951	INPATIENT DIALYSIS	286,068	0	286,068		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	FAMILY PRACTICE 120	204	0	204		88.00
90.00	09000	CLINIC	80,581	0	80,581		90.00
90.01	04950	WOUND CLINIC	122,945	0	122,945		90.01
91.00	09100	EMERGENCY	1,009,640	0	1,009,640		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	14,888	0	14,888		96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	181,952	0	181,952		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,682,143	0	12,682,143		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,037,108	0	4,037,108		192.00
192.01	19201	FP PETERSBURG	124,627	0	124,627		192.01
192.02	19202	PEDIATRICS	14,996	0	14,996		192.02
192.03	19203	WASHINGTON PRIMARY CARE	242,821	0	242,821		192.03
192.04	19204	FQHC	5,571	0	5,571		192.04

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
194.00	07950	COMMUNITY HEALTH SERVICES	15,134	0	15,134	194.00
194.01	07960	CCBHC GRANTS	20,922	0	20,922	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	61,610	0	61,610	194.02
194.03	07953	MH RESIDENTIAL	672,693	0	672,693	194.03
194.04	07954	UNUSED SPACE	671,574	0	671,574	194.04
194.05	07955	MOB	196	0	196	194.05
194.06	07956	FOUNDATION	15,366	0	15,366	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	155,350	0	155,350	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	1,216,247	0	1,216,247	194.09
194.10	07951	BEIRHAUS BUILDING	4,610	0	4,610	194.10
200.00		Cross Foot Adjustments	405,617	0	405,617	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	20,346,585	0	20,346,585	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	PURCHASING & RECEIVING (SUPPLIES COST)	
			1.00	2.00	4.00	4.01	4.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	884,498					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		884,498				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,862	4,862	109,523,338			4.00
4.01	00401	COMMUNICATIONS	0	0	324,521	2,110		4.01
4.02	00402	PURCHASING & RECEIVING	11,575	11,575	762,616	20	20,434,501	4.02
4.03	00403	REGISTRATION	11,304	11,304	1,806,704	37	8,536	4.03
4.04	00404	PATIENT ACCOUNTS	0	0	2,443,101	45	10,111	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	47,966	47,966	7,853,050	188	101,321	5.00
7.00	00700	OPERATION OF PLANT	239,930	239,930	2,576,329	121	209,439	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,266	5,266	239,763	0	81,699	8.00
9.00	00900	HOUSEKEEPING	7,326	7,326	2,339,766	37	219,056	9.00
10.00	01000	DIETARY	3,823	3,823	505,399	7	396,318	10.00
11.00	01100	CAFETERIA	8,696	8,696	1,401,049	20	1,098,658	11.00
13.00	01300	NURSING ADMINISTRATION	9,763	9,763	2,284,261	19	4,487	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,967	3,967	386,217	7	112,089	14.00
15.00	01500	PHARMACY	5,979	5,979	3,202,203	32	28,006	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,580	4,580	4,038,556	47	6,169	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	2,605	2,605	345,494	88	2,284	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	10,144	10,144	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	2,002,388	34	59,569	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	278,171	0	2,906	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	45,328	45,328	7,234,568	204	495,749	30.00
31.00	03100	INTENSIVE CARE UNIT	20,954	20,954	3,479,331	96	349,076	31.00
40.00	04000	SUBPROVIDER - IPF	13,034	13,034	2,236,192	0	27,212	40.00
41.00	04100	SUBPROVIDER - IRF	17,193	17,193	1,993,493	74	92,354	41.00
43.00	04300	NURSERY	10,434	10,434	278,493	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,026	24,026	3,308,341	147	857,729	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	12,237	12,237	845,525	26	635,443	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,306	6,306	168,319	23	56,064	52.00
53.00	05300	ANESTHESIOLOGY	0	0	2,861,645	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,666	21,666	4,961,683	95	832,891	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	17,985	17,985	2,937,306	37	103,613	55.00
60.00	06000	LABORATORY	7,298	7,298	2,441,210	34	1,466,637	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	5,679	5,679	2,724,194	39	16,348	65.00
66.00	06600	PHYSICAL THERAPY	28,346	28,346	5,788,311	62	51,304	66.00
69.00	06900	ELECTROCARDIOLOGY	18,181	18,181	5,104,267	81	236,181	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	7,708	7,708	889,678	20	46,886	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	6,724,882	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,236,655	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	1,221,011	0	486,903	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	8,582	8,582	93,493	2	2,825	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	0	0	21,835	0	0	88.00
90.00	09000	CLINIC	2,254	2,254	157,578	10	301	90.00
90.01	04950	WOUND CLINIC	2,976	2,976	372,480	10	141,467	90.01
91.00	09100	EMERGENCY	23,669	23,669	4,702,789	101	395,624	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	394	394	95,066	0	6,070	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	4,861	4,861	515,690	23	14,424	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	676,897	676,897	87,222,086	1,786	19,617,286	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	114,080	114,080	15,028,004	291	655,352	192.00
192.01	19201	FP PETERSBURG	3,705	3,705	130,307	0	1,951	192.01
192.02	19202	PEDIATRICS	0	0	920,415	20	42,539	192.02

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	PURCHASING & RECEIVING (SUPPLIES COST)	
			1.00	2.00	4.00	4.01	4.02	
192.03	19203	WASHINGTON PRIMARY CARE	6,800	6,800	1,426,504	0	33,113	192.03
192.04	19204	FQHC	0	0	0	0	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	415	415	118,041	4	1,306	194.00
194.01	07960	CCBHC GRANTS	0	0	1,011,558	0	22,336	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	1,690	1,690	260,331	6	475	194.02
194.03	07953	MH RESIDENTIAL	20,260	20,260	274,107	0	16,239	194.03
194.04	07954	UNUSED SPACE	20,370	20,370	0	0	0	194.04
194.05	07955	MOB	0	0	160	0	0	194.05
194.06	07956	FOUNDATION	466	466	0	3	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	4,712	4,712	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	35,103	35,103	3,131,825	0	43,427	194.09
194.10	07951	BEIRHAUS BUILDING	0	0	0	0	477	194.10
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)	20,306,497	40,088	28,526,464	295,265	1,247,874	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.958217	0.045323	0.260460	139.936019	0.061067	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			111,843	331	267,048	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001021	0.156872	0.013068	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: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	REGISTRATION (GROSS CHARGES)	PATIENT ACCOUNTS (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			4.03	4.04	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION	648,458,527					4.03
4.04	00404	PATIENT ACCOUNTS	0	648,458,527				4.04
5.00	00500	ADMINISTRATIVE & GENERAL	0	0	-22,865,895	208,034,233		5.00
7.00	00700	OPERATION OF PLANT	0	0	0	13,877,169	568,861	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	528,007	5,266	8.00
9.00	00900	HOUSEKEEPING	0	0	0	3,357,429	7,326	9.00
10.00	01000	DIETARY	0	0	0	1,132,647	3,823	10.00
11.00	01100	CAFETERIA	0	0	0	1,862,313	8,696	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	5,136,038	9,763	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	800,318	3,967	14.00
15.00	01500	PHARMACY	0	0	0	4,294,444	5,979	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	5,654,874	4,580	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	0	0	728,004	2,605	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	3,868,087	10,144	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	3,376,102	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	345,335	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,027,998	32,027,998	0	13,444,606	45,328	30.00
31.00	03100	INTENSIVE CARE UNIT	12,422,932	12,422,932	0	6,090,527	20,954	31.00
40.00	04000	SUBPROVIDER - IPF	9,285,009	9,285,009	0	3,821,176	13,034	40.00
41.00	04100	SUBPROVIDER - IRF	7,916,191	7,916,191	0	3,297,823	17,193	41.00
43.00	04300	NURSERY	1,245,687	1,245,687	0	636,050	10,434	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	44,116,643	44,116,643	0	6,138,688	24,026	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	13,308,153	13,308,153	0	2,303,675	12,237	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,061,064	2,061,064	0	405,455	6,306	52.00
53.00	05300	ANESTHESIOLOGY	8,188,147	8,188,147	0	1,492,321	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	114,449,658	114,449,658	0	10,709,216	21,666	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	27,451,180	27,451,180	0	4,582,940	17,985	55.00
60.00	06000	LABORATORY	81,778,189	81,778,189	0	9,302,053	7,298	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	12,333,717	12,333,717	0	3,389,802	5,679	65.00
66.00	06600	PHYSICAL THERAPY	26,424,681	26,424,681	0	6,624,278	28,346	66.00
69.00	06900	ELECTROCARDIOLOGY	44,274,847	44,274,847	0	5,255,092	18,181	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	6,319,021	6,319,021	0	1,524,145	7,708	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,319,868	3,319,868	0	4,122,460	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,773,053	12,773,053	0	4,648,855	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	93,432,655	93,432,655	0	20,555,648	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	29,138,855	29,138,855	0	2,706,980	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	1,009,629	1,009,629	0	481,736	8,582	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	46,689	46,689	0	30,507	0	88.00
90.00	09000	CLINIC	124,872	124,872	0	254,515	2,254	90.00
90.01	04950	WOUND CLINIC	5,370,889	5,370,889	0	1,227,448	2,976	90.01
91.00	09100	EMERGENCY	57,539,520	57,539,520	0	8,217,110	23,669	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	455,308	455,308	0	197,825	394	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,644,072	1,644,072	0	1,150,140	4,861	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	648,458,527	648,458,527	-22,865,895	167,571,838	361,260	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	26,490,764	114,080	192.00
192.01	19201	FP PETERSBURG	0	0	0	374,710	3,705	192.01
192.02	19202	PEDIATRICS	0	0	0	1,445,141	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	0	0	2,177,377	6,800	192.03
192.04	19204	FQHC	0	0	72	0	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	173,116	415	194.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	REGISTRATION (GROSS CHARGES)	PATIENT ACCOUNTS (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			4.03	4.04	5A	5.00	7.00	
194.01	07960	CCBHC GRANTS	0	0	0	2,250,781	0	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	871,646	1,690	194.02
194.03	07953	MH RESIDENTIAL	0	0	0	836,874	20,260	194.03
194.04	07954	UNUSED SPACE	0	0	0	468,582	20,370	194.04
194.05	07955	MOB	0	0	0	36,700	0	194.05
194.06	07956	FOUNDATION	0	0	0	11,140	466	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	108,393	4,712	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	0	0	5,101,005	35,103	194.09
194.10	07951	BEIRHAUS BUILDING	0	0	0	116,166	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,559,450	4,574,842		22,865,895	15,402,464	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.003947	0.007055		0.109914	27.075971	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	261,995	2,633		1,112,759	5,598,853	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000404	0.000004		0.005349	9.842216	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: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NURSING)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	849,322					8.00
9.00	00900	HOUSEKEEPING	35,751	70,437				9.00
10.00	01000	DIETARY	2,891	1,742	28,929			10.00
11.00	01100	CAFETERIA	8,014	411	0	2,076,592		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	52,829	805,136	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,168	763	0	15,978	0	14.00
15.00	01500	PHARMACY	0	603	0	69,455	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	616	0	124,147	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	1,880	0	7,166	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	63	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	1,435	0	36,048	36,048	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	6,860	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	257,289	11,553	13,542	152,152	147,824	30.00
31.00	03100	INTENSIVE CARE UNIT	45,435	4,072	4,812	89,895	89,895	31.00
40.00	04000	SUBPROVIDER - IPF	14,951	0	4,323	59,615	59,615	40.00
41.00	04100	SUBPROVIDER - IRF	41,210	3,054	6,252	61,425	61,425	41.00
43.00	04300	NURSERY	59,223	2,659	0	35,023	34,026	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,852	2,983	0	68,960	52,906	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	19,471	1,018	0	25,119	25,119	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	35,794	1,607	0	21,168	20,565	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	15,098	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,743	2,029	0	111,956	11,539	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,975	1,171	0	60,807	40,644	55.00
60.00	06000	LABORATORY	0	944	0	96,907	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,862	674	0	63,779	0	65.00
66.00	06600	PHYSICAL THERAPY	16,203	2,931	0	129,217	33,138	66.00
69.00	06900	ELECTROCARDIOLOGY	18,425	3,255	0	83,561	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	9,137	918	0	20,664	3,001	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	29,733	2,879	0	38,559	38,559	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	1,706	1,706	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	0	0	0	0	0	88.00
90.00	09000	CLINIC	56	1,116	0	4,335	0	90.00
90.01	04950	WOUND CLINIC	13,171	348	0	10,586	2,499	90.01
91.00	09100	EMERGENCY	103,079	4,212	0	122,624	122,624	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	3,158	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,181	0	16,894	16,894	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	817,433	56,054	28,929	1,605,754	798,027	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	31,889	13,013	0	311,189	7,109	192.00
192.01	19201	FP PETERSBURG	0	0	0	4,639	0	192.01
192.02	19202	PEDIATRICS	0	0	0	21,882	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	0	0	31,619	0	192.03
192.04	19204	FQHC	0	282	0	29,601	0	192.04

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NURSING)	
			8.00	9.00	10.00	11.00	13.00	
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	2,792	0	194.00
194.01	07960	CCBHC GRANTS	0	55	0	47,310	0	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	7,666	0	194.02
194.03	07953	MH RESIDENTIAL	0	0	0	14,140	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	0	0	0	0	194.09
194.10	07951	BEIRHAUS BUILDING	0	1,033	0	0	0	194.10
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)	728,624	3,955,486	1,460,956	2,332,415	6,024,240	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.857889	56.156367	50.501435	1.123194	7.482264	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	177,103	271,300	144,637	314,633	358,544	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.208523	3.851669	4.999723	0.151514	0.445321	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: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (SUPPLIES COST)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (NET CHARGES)	MENTAL HEALTH OH (NET CHARGES)	
			14.00	15.00	16.00	17.00	17.01	
		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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,192,787					14.00
15.00	01500	PHARMACY	28,006	22,028,426				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,169	0	812			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0		17.00
17.01	01701	MENTAL HEALTH OH	2,284	0	0	0	13,818,330	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	59,569	9,021	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	2,906	0	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	495,749	997	108	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	349,076	110	92	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	27,212	2	101	0	9,333,957	40.00
41.00	04100	SUBPROVIDER - IRF	92,354	8,306	65	0	0	41.00
43.00	04300	NURSERY	0	229	8	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	857,729	15,971	34	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	635,443	633	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	56,064	139	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	832,891	496,679	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	103,613	6,465	0	0	0	55.00
60.00	06000	LABORATORY	1,466,637	49	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	16,348	2,134	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	51,304	86,983	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	236,181	1,547	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	46,886	37	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,724,882	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,236,655	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,937,599	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	486,903	15,937	220	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	2,825	2,361	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	0	0	0	0	0	88.00
90.00	09000	CLINIC	301	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	141,467	17,446	24	0	0	90.01
91.00	09100	EMERGENCY	395,624	12,164	160	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	6,070	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	14,424	26	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,375,572	20,614,835	812	0	9,333,957	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	655,352	1,128,794	0	0	0	192.00
192.01	19201	FP PETERSBURG	1,951	4,956	0	0	0	192.01
192.02	19202	PEDIATRICS	42,539	197,303	0	0	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	33,113	82,152	0	0	0	192.03
192.04	19204	FQHC	0	0	0	0	0	192.04

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (SUPPLIES COST)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (NET CHARGES)	MENTAL HEALTH OH (NET CHARGES)	
			14.00	15.00	16.00	17.00	17.01	
194.00	07950	COMMUNITY HEALTH SERVICES	1,306	384	0	0	0	194.00
194.01	07960	CCBHC GRANTS	22,336	2	0	0	0	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	475	0	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	16,239	0	0	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	43,427	0	0	0	4,484,373	194.09
194.10	07951	BEIRHAUS BUILDING	477	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,068,642	5,041,869	6,574,827	0	992,312	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.058740	0.228880	8,097.077586	0.000000	0.071811	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	144,754	236,065	206,125	0	98,199	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.007957	0.010716	253.848522	0.000000	0.007106	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: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 4/11/2024 3:17 pm

		Cost Center Description	INTERNS & RESIDENTS					
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LAB (ASSIGNED TIME)		
			21.00	22.00	23.00	23.01		
		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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
17.01	01701	MENTAL HEALTH OH						17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	4,395					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		4,395				22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY			0			23.00
23.01	02301	PARAMED ED PRGM-LAB				100		23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	850	850	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	33	33	0	0		31.00
40.00	04000	SUBPROVIDER - IPF	322	322	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
51.01	05101	ENDOSCOPY	151	151	0	0		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	14	14	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8	8	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	47	47	0	0		55.00
60.00	06000	LABORATORY	0	0	0	100		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	38	38	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	31	31	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0		76.00
76.01	03951	INPATIENT DIALYSIS	62	62	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	0	0	0	0		88.00
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	04950	WOUND CLINIC	0	0	0	0		90.01
91.00	09100	EMERGENCY	1,106	1,106	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE			0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,662	2,662	0	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	703	703	0	0		192.00
192.01	19201	FP PETERSBURG	0	0	0	0		192.01
192.02	19202	PEDIATRICS	0	0	0	0		192.02

		Cost Center Description	INTERNS & RESIDENTS					
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LAB (ASSIGNED TIME)		
			21.00	22.00	23.00	23.01		
192.03	19203	WASHINGTON PRIMARY CARE	0	0	0	0		192.03
192.04	19204	FQHC	0	0	0	0		192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	0		194.00
194.01	07960	CCBHC GRANTS	0	0	0	0		194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	0		194.02
194.03	07953	MH RESIDENTIAL	0	0	0	0		194.03
194.04	07954	UNUSED SPACE	0	0	0	0		194.04
194.05	07955	MOB	0	0	0	0		194.05
194.06	07956	FOUNDATION	0	0	0	0		194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0		194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0		194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	1,030	1,030	0	0		194.09
194.10	07951	BEIRHAUS BUILDING	0	0	0	0		194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,567,974	4,143,541	0	391,168		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,039.356997	942.785210	0.000000	3,911.680000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	353,887	48,499	0	3,231		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	80.520364	11.035040	0.000000	32.310000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			0	0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000	0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 4/11/2024 3:17 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	19,883,833		19,883,833	0	19,883,833	30.00
31.00	03100	INTENSIVE CARE UNIT	9,377,020		9,377,020	0	9,377,020	31.00
40.00	04000	SUBPROVIDER - IPF	6,827,931		6,827,931	0	6,827,931	40.00
41.00	04100	SUBPROVIDER - IRF	5,710,634		5,710,634	0	5,710,634	41.00
43.00	04300	NURSERY	1,547,358		1,547,358	0	1,547,358	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,462,291		8,462,291	1,577	8,463,868	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
51.01	05101	ENDOSCOPY	3,215,713		3,215,713	0	3,215,713	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	922,685		922,685	0	922,685	52.00
53.00	05300	ANESTHESIOLOGY	1,673,306		1,673,306	0	1,673,306	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,005,100		13,005,100	0	13,005,100	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,026,204		6,026,204	20,647	6,046,851	55.00
60.00	06000	LABORATORY	11,161,265		11,161,265	86,322	11,247,587	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	4,028,683	0	4,028,683	0	4,028,683	65.00
66.00	06600	PHYSICAL THERAPY	8,714,374	0	8,714,374	0	8,714,374	66.00
69.00	06900	ELECTROCARDIOLOGY	6,631,646		6,631,646	849	6,632,495	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	2,008,189		2,008,189	6,738	2,014,927	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,970,593		4,970,593	0	4,970,593	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,408,690		5,408,690	0	5,408,690	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,378,324		27,378,324	0	27,378,324	73.00
75.00	07500	ASC (NON-DISTINCT PART)	5,337,121		5,337,121	7,036	5,344,157	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0		0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	782,439		782,439	0	782,439	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	33,860		33,860	0	33,860	88.00
90.00	09000	CLINIC	411,125		411,125	0	411,125	90.00
90.01	04950	WOUND CLINIC	1,711,002		1,711,002	0	1,711,002	90.01
91.00	09100	EMERGENCY	12,462,898		12,462,898	31,374	12,494,272	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,138,541		4,138,541		4,138,541	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	234,141		234,141	0	234,141	96.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,620,726		1,620,726		1,620,726	116.00
200.00		Subtotal (see instructions)	173,685,692	0	173,685,692	154,543	173,840,235	200.00
201.00		Less Observation Beds	4,138,541		4,138,541		4,138,541	201.00
202.00		Total (see instructions)	169,547,151	0	169,547,151	154,543	169,701,694	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 4/11/2024 3:17 pm

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		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,723,934		18,723,934			30.00
31.00	03100	INTENSIVE CARE UNIT	12,422,932		12,422,932			31.00
40.00	04000	SUBPROVIDER - IPF	9,285,009		9,285,009			40.00
41.00	04100	SUBPROVIDER - IRF	7,916,191		7,916,191			41.00
43.00	04300	NURSERY	1,245,687		1,245,687			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,113,836	29,002,807	44,116,643	0.191816	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
51.01	05101	ENDOSCOPY	1,206,777	12,101,376	13,308,153	0.241635	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,031,744	29,320	2,061,064	0.447674	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,197,115	5,991,032	8,188,147	0.204357	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,982,883	97,466,775	114,449,658	0.113632	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	876,922	26,574,258	27,451,180	0.219524	0.000000	55.00
60.00	06000	LABORATORY	21,790,847	59,987,342	81,778,189	0.136482	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	8,600,839	3,732,878	12,333,717	0.326640	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	14,551,640	11,873,041	26,424,681	0.329782	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	15,513,561	28,761,286	44,274,847	0.149784	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	243,470	6,075,551	6,319,021	0.317801	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,743,931	1,575,937	3,319,868	1.497226	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,103,281	9,669,772	12,773,053	0.423445	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,614,831	76,817,824	93,432,655	0.293027	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	309,932	28,828,923	29,138,855	0.183162	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0.000000	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	951,401	58,228	1,009,629	0.774977	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	833	45,856	46,689			88.00
90.00	09000	CLINIC	129	124,743	124,872	3.292371	0.000000	90.00
90.01	04950	WOUND CLINIC	66,558	5,304,331	5,370,889	0.318570	0.000000	90.01
91.00	09100	EMERGENCY	11,659,417	45,880,103	57,539,520	0.216597	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,394,991	8,909,073	13,304,064	0.311073	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	455,308	455,308	0.514247	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,644,072	1,644,072			116.00
200.00		Subtotal (see instructions)	187,548,691	460,909,836	648,458,527			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	187,548,691	460,909,836	648,458,527			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.191852	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
51.01	05101	ENDOSCOPY	0.241635	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.447674	52.00
53.00	05300	ANESTHESIOLOGY	0.204357	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113632	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.220277	55.00
60.00	06000	LABORATORY	0.137538	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0.326640	65.00
66.00	06600	PHYSICAL THERAPY	0.329782	66.00
69.00	06900	ELECTROCARDIOLOGY	0.149803	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0.318867	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.497226	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.423445	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293027	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.183403	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	0.774977	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	FAMILY PRACTICE 120		88.00
90.00	09000	CLINIC	3.292371	90.00
90.01	04950	WOUND CLINIC	0.318570	90.01
91.00	09100	EMERGENCY	0.217142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.311073	92.00
		OTHER REIMBURSABLE COST CENTERS		
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.514247	96.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
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: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 4/11/2024 3:17 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
					Costs			
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,883,833		19,883,833	0	19,883,833	30.00
31.00	03100	INTENSIVE CARE UNIT	9,377,020		9,377,020	0	9,377,020	31.00
40.00	04000	SUBPROVIDER - IPF	6,827,931		6,827,931	0	6,827,931	40.00
41.00	04100	SUBPROVIDER - IRF	5,710,634		5,710,634	0	5,710,634	41.00
43.00	04300	NURSERY	1,547,358		1,547,358	0	1,547,358	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,462,291		8,462,291	1,577	8,463,868	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
51.01	05101	ENDOSCOPY	3,215,713		3,215,713	0	3,215,713	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	922,685		922,685	0	922,685	52.00
53.00	05300	ANESTHESIOLOGY	1,673,306		1,673,306	0	1,673,306	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,005,100		13,005,100	0	13,005,100	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,026,204		6,026,204	20,647	6,046,851	55.00
60.00	06000	LABORATORY	11,161,265		11,161,265	86,322	11,247,587	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	4,028,683	0	4,028,683	0	4,028,683	65.00
66.00	06600	PHYSICAL THERAPY	8,714,374	0	8,714,374	0	8,714,374	66.00
69.00	06900	ELECTROCARDIOLOGY	6,631,646		6,631,646	849	6,632,495	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	2,008,189		2,008,189	6,738	2,014,927	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,970,593		4,970,593	0	4,970,593	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,408,690		5,408,690	0	5,408,690	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,378,324		27,378,324	0	27,378,324	73.00
75.00	07500	ASC (NON-DISTINCT PART)	5,337,121		5,337,121	7,036	5,344,157	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0		0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	782,439		782,439	0	782,439	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	33,860		33,860	0	33,860	88.00
90.00	09000	CLINIC	411,125		411,125	0	411,125	90.00
90.01	04950	WOUND CLINIC	1,711,002		1,711,002	0	1,711,002	90.01
91.00	09100	EMERGENCY	12,462,898		12,462,898	31,374	12,494,272	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,138,541		4,138,541		4,138,541	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	234,141		234,141	0	234,141	96.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,620,726		1,620,726		1,620,726	116.00
200.00		Subtotal (see instructions)	173,685,692	0	173,685,692	154,543	173,840,235	200.00
201.00		Less Observation Beds	4,138,541		4,138,541		4,138,541	201.00
202.00		Total (see instructions)	169,547,151	0	169,547,151	154,543	169,701,694	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 4/11/2024 3:17 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges					
			Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,723,934		18,723,934			30.00
31.00	03100	INTENSIVE CARE UNIT	12,422,932		12,422,932			31.00
40.00	04000	SUBPROVIDER - IPF	9,285,009		9,285,009			40.00
41.00	04100	SUBPROVIDER - IRF	7,916,191		7,916,191			41.00
43.00	04300	NURSERY	1,245,687		1,245,687			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,113,836	29,002,807	44,116,643	0.191816	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
51.01	05101	ENDOSCOPY	1,206,777	12,101,376	13,308,153	0.241635	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,031,744	29,320	2,061,064	0.447674	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,197,115	5,991,032	8,188,147	0.204357	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,982,883	97,466,775	114,449,658	0.113632	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	876,922	26,574,258	27,451,180	0.219524	0.000000	55.00
60.00	06000	LABORATORY	21,790,847	59,987,342	81,778,189	0.136482	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	8,600,839	3,732,878	12,333,717	0.326640	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	14,551,640	11,873,041	26,424,681	0.329782	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	15,513,561	28,761,286	44,274,847	0.149784	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	243,470	6,075,551	6,319,021	0.317801	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,743,931	1,575,937	3,319,868	1.497226	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,103,281	9,669,772	12,773,053	0.423445	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,614,831	76,817,824	93,432,655	0.293027	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	309,932	28,828,923	29,138,855	0.183162	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0.000000	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	951,401	58,228	1,009,629	0.774977	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	833	45,856	46,689	0.725224	0.000000	88.00
90.00	09000	CLINIC	129	124,743	124,872	3.292371	0.000000	90.00
90.01	04950	WOUND CLINIC	66,558	5,304,331	5,370,889	0.318570	0.000000	90.01
91.00	09100	EMERGENCY	11,659,417	45,880,103	57,539,520	0.216597	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,394,991	8,909,073	13,304,064	0.311073	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	455,308	455,308	0.514247	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,644,072	1,644,072			116.00
200.00		Subtotal (see instructions)	187,548,691	460,909,836	648,458,527			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	187,548,691	460,909,836	648,458,527			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 4/11/2024 3:17 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
51.01	05101	ENDOSCOPY	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	FAMILY PRACTICE 120	0.000000	88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	04950	WOUND CLINIC	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I | Date/Time Prepared: 4/11/2024 3:17 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	1,873,820	0	1,873,820	12,266	152.77	30.00
31.00	INTENSIVE CARE UNIT	863,028		863,028	4,812	179.35	31.00
40.00	SUBPROVIDER - IPF	607,479	0	607,479	4,323	140.52	40.00
41.00	SUBPROVIDER - IRF	694,440	0	694,440	6,252	111.07	41.00
43.00	NURSERY	391,989		391,989	816	480.38	43.00
200.00	Total (lines 30 through 199)	4,430,756		4,430,756	28,469		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	4,497	687,007	30.00
31.00	INTENSIVE CARE UNIT	1,988	356,548	31.00
40.00	SUBPROVIDER - IPF	532	74,757	40.00
41.00	SUBPROVIDER - IRF	4,578	508,478	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	11,595	1,626,790	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	922,572	44,116,643	0.020912	5,824,453	121,801	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	456,892	13,308,153	0.034332	427,611	14,681	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	237,511	2,061,064	0.115237	5,064	584	52.00
53.00	05300	ANESTHESIOLOGY	16,533	8,188,147	0.002019	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	884,087	114,449,658	0.007725	7,593,466	58,660	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	665,183	27,451,180	0.024231	33,326	808	55.00
60.00	06000	LABORATORY	374,483	81,778,189	0.004579	8,744,772	40,042	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	225,496	12,333,717	0.018283	2,613,422	47,781	65.00
66.00	06600	PHYSICAL THERAPY	1,034,194	26,424,681	0.039137	2,812,793	110,084	66.00
69.00	06900	ELECTROCARDIOLOGY	682,587	44,274,847	0.015417	7,096,121	109,401	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	275,711	6,319,021	0.043632	34,184	1,492	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	164,799	3,319,868	0.049640	739,555	36,712	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	119,154	12,773,053	0.009329	1,596,093	14,890	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	361,735	93,432,655	0.003872	5,616,702	21,748	73.00
75.00	07500	ASC (NON-DISTINCT PART)	134,172	29,138,855	0.004605	212	1	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	286,068	1,009,629	0.283340	409,165	115,933	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	FAMILY PRACTICE 120	204	46,689	0.004369	0	0	88.00
90.00	09000	CLINIC	80,581	124,872	0.645309	0	0	90.00
90.01	04950	WOUND CLINIC	122,945	5,370,889	0.022891	7,783	178	90.01
91.00	09100	EMERGENCY	1,009,640	57,539,520	0.017547	4,485,503	78,707	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	390,008	13,304,064	0.029315	2,003,004	58,718	92.00
	OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	14,888	455,308	0.032699	0	0	96.00
200.00		Total (lines 50 through 199)	8,459,443	597,220,702		50,043,229	832,221	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	12,266	0.00	4,497	30.00
31.00	03100	INTENSIVE CARE UNIT		0	4,812	0.00	1,988	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,323	0.00	532	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	6,252	0.00	4,578	41.00
43.00	04300	NURSERY		0	816	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	28,469		11,595	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	391,168	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	391,168	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	44,116,643	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
51.01	05101	ENDOSCOPY	0	0	0	13,308,153	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,061,064	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	8,188,147	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	114,449,658	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	27,451,180	0.000000	55.00
60.00	06000	LABORATORY	0	391,168	391,168	81,778,189	0.004783	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,333,717	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	26,424,681	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	44,274,847	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	6,319,021	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,319,868	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,773,053	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	93,432,655	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	29,138,855	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	1,009,629	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	0	0	0	46,689	0.000000	88.00
90.00	09000	CLINIC	0	0	0	124,872	0.000000	90.00
90.01	04950	WOUND CLINIC	0	0	0	5,370,889	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	57,539,520	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	13,304,064	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	455,308	0.000000	96.00
200.00		Total (lines 50 through 199)	0	391,168	391,168	597,220,702		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	5,824,453	0	9,089,991	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.000000	427,611	0	3,692,702	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	5,064	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	7,593,466	0	30,950,516	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	33,326	0	13,180,466	0	55.00
60.00	06000	LABORATORY	0.004783	8,744,772	41,826	7,190,947	34,394	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,613,422	0	1,277,294	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,812,793	0	689,105	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	7,096,121	0	12,432,256	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.000000	34,184	0	1,724,693	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	739,555	0	673,163	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,596,093	0	3,782,807	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,616,702	0	38,487,586	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	212	0	8,134,770	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.000000	409,165	0	14,215	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	2,334	0	90.00
90.01	04950	WOUND CLINIC	0.000000	7,783	0	2,070,088	0	90.01
91.00	09100	EMERGENCY	0.000000	4,485,503	0	8,863,784	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2,003,004	0	1,565,489	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		50,043,229	41,826	143,822,206	34,394	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.191816	9,089,991	0	0	1,743,606	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.241635	3,692,702	0	0	892,286	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.447674	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.204357	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113632	30,950,516	0	0	3,516,969	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.219524	13,180,466	0	0	2,893,429	55.00
60.00	06000	LABORATORY	0.136482	7,190,947	0	0	981,435	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.326640	1,277,294	0	0	417,215	65.00
66.00	06600	PHYSICAL THERAPY	0.329782	689,105	0	0	227,254	66.00
69.00	06900	ELECTROCARDIOLOGY	0.149784	12,432,256	0	0	1,862,153	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.317801	1,724,693	0	0	548,109	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.497226	673,163	0	0	1,007,877	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.423445	3,782,807	0	0	1,601,811	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293027	38,487,586	0	10,864	11,277,902	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.183162	8,134,770	0	0	1,489,981	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.774977	14,215	0	0	11,016	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120						88.00
90.00	09000	CLINIC	3.292371	2,334	0	0	7,684	90.00
90.01	04950	WOUND CLINIC	0.318570	2,070,088	0	0	659,468	90.01
91.00	09100	EMERGENCY	0.216597	8,863,784	0	163	1,919,869	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.311073	1,565,489	0	0	486,981	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.514247	0	0	0	0	96.00
200.00		Subtotal (see instructions)		143,822,206	0	11,027	31,545,045	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		143,822,206	0	11,027	31,545,045	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,183	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	FAMILY PRACTICE 120			88.00
90.00	09000	CLINIC	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	90.01
91.00	09100	EMERGENCY	0	35	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	0	3,218	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	3,218	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II

Component CCN: 15-S042 | Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	922,572	44,116,643	0.020912	12,660	265	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	456,892	13,308,153	0.034332	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	237,511	2,061,064	0.115237	0	0	52.00
53.00	05300	ANESTHESIOLOGY	16,533	8,188,147	0.002019	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	884,087	114,449,658	0.007725	16,119	125	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	665,183	27,451,180	0.024231	0	0	55.00
60.00	06000	LABORATORY	374,483	81,778,189	0.004579	137,955	632	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	225,496	12,333,717	0.018283	25,379	464	65.00
66.00	06600	PHYSICAL THERAPY	1,034,194	26,424,681	0.039137	7,373	289	66.00
69.00	06900	ELECTROCARDIOLOGY	682,587	44,274,847	0.015417	11,463	177	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	275,711	6,319,021	0.043632	4,127	180	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	164,799	3,319,868	0.049640	1,845	92	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	119,154	12,773,053	0.009329	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	361,735	93,432,655	0.003872	90,869	352	73.00
75.00	07500	ASC (NON-DISTINCT PART)	134,172	29,138,855	0.004605	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	286,068	1,009,629	0.283340	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	204	46,689	0.004369	0	0	88.00
90.00	09000	CLINIC	80,581	124,872	0.645309	0	0	90.00
90.01	04950	WOUND CLINIC	122,945	5,370,889	0.022891	0	0	90.01
91.00	09100	EMERGENCY	1,009,640	57,539,520	0.017547	169,069	2,967	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	13,304,064	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	14,888	455,308	0.032699	0	0	96.00
200.00		Total (lines 50 through 199)	8,069,435	597,220,702		476,859	5,543	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042
Component CCN: 15-S042

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

Worksheet D Part IV
Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	391,168	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	391,168	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	44,116,643	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
51.01	05101	ENDOSCOPY	0	0	0	13,308,153	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,061,064	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	8,188,147	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	114,449,658	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	27,451,180	0.000000	55.00
60.00	06000	LABORATORY	0	391,168	391,168	81,778,189	0.004783	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,333,717	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	26,424,681	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	44,274,847	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	6,319,021	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,319,868	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,773,053	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	93,432,655	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	29,138,855	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	1,009,629	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	0	0	0	46,689	0.000000	88.00
90.00	09000	CLINIC	0	0	0	124,872	0.000000	90.00
90.01	04950	WOUND CLINIC	0	0	0	5,370,889	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	57,539,520	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	13,304,064	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	455,308	0.000000	96.00
200.00		Total (lines 50 through 199)	0	391,168	391,168	597,220,702		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	12,660	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.000000	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	16,119	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.004783	137,955	660	318	2	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	25,379	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	7,373	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	11,463	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.000000	4,127	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,845	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	90,869	0	244	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	169,069	0	3,924	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		476,859	660	4,486	2	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 4/11/2024 3:17 pm
	Title XVIII	Subprovider - IPF	PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.191816	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.241635	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.447674	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.204357	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113632	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.219524	0	0	0	0	55.00
60.00	06000	LABORATORY	0.136482	318	0	0	43	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.326640	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.329782	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.149784	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.317801	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.497226	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.423445	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293027	244	0	215	71	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.183162	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.774977	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120						88.00
90.00	09000	CLINIC	3.292371	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0.318570	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.216597	3,924	0	0	850	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.311073	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.514247	0	0	0	0	96.00
200.00		Subtotal (see instructions)		4,486	0	215	964	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		4,486	0	215	964	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	63	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	FAMILY PRACTICE 120			88.00
90.00	09000	CLINIC	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	0	63	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	63	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II | Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	922,572	44,116,643	0.020912	20,176	422	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	456,892	13,308,153	0.034332	10,411	357	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	237,511	2,061,064	0.115237	0	0	52.00
53.00	05300	ANESTHESIOLOGY	16,533	8,188,147	0.002019	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	884,087	114,449,658	0.007725	373,671	2,887	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	665,183	27,451,180	0.024231	0	0	55.00
60.00	06000	LABORATORY	374,483	81,778,189	0.004579	856,821	3,923	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	225,496	12,333,717	0.018283	837,151	15,306	65.00
66.00	06600	PHYSICAL THERAPY	1,034,194	26,424,681	0.039137	6,557,973	256,659	66.00
69.00	06900	ELECTROCARDIOLOGY	682,587	44,274,847	0.015417	79,630	1,228	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	275,711	6,319,021	0.043632	2,828	123	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	164,799	3,319,868	0.049640	90,696	4,502	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	119,154	12,773,053	0.009329	700	7	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	361,735	93,432,655	0.003872	985,238	3,815	73.00
75.00	07500	ASC (NON-DISTINCT PART)	134,172	29,138,855	0.004605	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	286,068	1,009,629	0.283340	96,281	27,280	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	204	46,689	0.004369	0	0	88.00
90.00	09000	CLINIC	80,581	124,872	0.645309	0	0	90.00
90.01	04950	WOUND CLINIC	122,945	5,370,889	0.022891	0	0	90.01
91.00	09100	EMERGENCY	1,009,640	57,539,520	0.017547	93,257	1,636	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	13,304,064	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	14,888	455,308	0.032699	0	0	96.00
200.00		Total (lines 50 through 199)	8,069,435	597,220,702		10,004,833	318,145	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	391,168	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	391,168	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 4/11/2024 3:17 pm
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	44,116,643	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
51.01	05101	ENDOSCOPY	0	0	0	13,308,153	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,061,064	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	8,188,147	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	114,449,658	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	27,451,180	0.000000	55.00
60.00	06000	LABORATORY	0	391,168	391,168	81,778,189	0.004783	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,333,717	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	26,424,681	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	44,274,847	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	6,319,021	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,319,868	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,773,053	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	93,432,655	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	29,138,855	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	1,009,629	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	0	0	0	46,689	0.000000	88.00
90.00	09000	CLINIC	0	0	0	124,872	0.000000	90.00
90.01	04950	WOUND CLINIC	0	0	0	5,370,889	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	57,539,520	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	13,304,064	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	455,308	0.000000	96.00
200.00		Total (lines 50 through 199)	0	391,168	391,168	597,220,702		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	20,176	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.000000	10,411	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	373,671	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.004783	856,821	4,098	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	837,151	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	6,557,973	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	79,630	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.000000	2,828	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	90,696	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	700	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	985,238	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.000000	96,281	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	978	0	90.00
90.01	04950	WOUND CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	93,257	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		10,004,833	4,098	978	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.191816	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.241635	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.447674	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.204357	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113632	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.219524	0	0	0	0	55.00
60.00	06000	LABORATORY	0.136482	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.326640	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.329782	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.149784	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.317801	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.497226	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.423445	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293027	0	0	974	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.183162	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.774977	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120						88.00
90.00	09000	CLINIC	3.292371	978	0	0	3,220	90.00
90.01	04950	WOUND CLINIC	0.318570	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.216597	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.311073	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.514247	0	0	0	0	96.00
200.00		Subtotal (see instructions)		978	0	974	3,220	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		978	0	974	3,220	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	285	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	FAMILY PRACTICE 120			88.00
90.00	09000	CLINIC	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	0	285	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	285	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,266	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,266	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)	9,713	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)	4,497	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)	19,883,833	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)	19,883,833	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)	19,883,833	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)	1,621.05	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,289,862	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)	7,289,862	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 4/11/2024 3:17 pm

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	9,377,020	4,812	1,948.67	1,988	3,873,956	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)	11,496,809	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)	22,660,627	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)	1,043,555	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	874,047	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,917,602	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	20,743,025	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)	2,553	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,621.05	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 4/11/2024 3:17 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,138,541	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	1,873,820	19,883,833	0.094238	4,138,541	390,008	90.00
91.00	Nursing Program cost	0	19,883,833	0.000000	4,138,541	0	91.00
92.00	Allied health cost	0	19,883,833	0.000000	4,138,541	0	92.00
93.00	All other Medical Education	0	19,883,833	0.000000	4,138,541	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 4/11/2024 3:17 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,323	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,323	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)	4,323	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)	532	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)	6,827,931	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)	6,827,931	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,827,931	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)	1,579.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	840,262	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)	840,262	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	103,090	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)	943,352	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)	74,757	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	6,203	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	80,960	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	862,392	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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 4/11/2024 3:17 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
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	607,479	6,827,931	0.088970	0	0	90.00
91.00	Nursing Program cost	0	6,827,931	0.000000	0	0	91.00
92.00	Allied health cost	0	6,827,931	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,827,931	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,252	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,252	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)	6,252	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)	4,578	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)	5,710,634	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)	5,710,634	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)	5,710,634	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)	913.41	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,181,591	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)	4,181,591	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	3,135,327	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)	7,316,918	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)	508,478	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	322,243	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	830,721	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	6,486,197	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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 4/11/2024 3:17 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
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	694,440	5,710,634	0.121605	0	0	90.00
91.00	Nursing Program cost	0	5,710,634	0.000000	0	0	91.00
92.00	Allied health cost	0	5,710,634	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,710,634	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 4/11/2024 3:17 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,266	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,266	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)	9,713	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)	405	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)	816	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)	19,883,833	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)	19,883,833	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)	19,883,833	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)	1,621.05	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	656,525	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)	656,525	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 4/11/2024 3:17 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,547,358	816	1,896.27	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	9,377,020	4,812	1,948.67	0	0	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)	460,663	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)	1,117,188	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,553	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,621.05	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 4/11/2024 3:17 pm
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,138,541	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	1,873,820	19,883,833	0.094238	4,138,541	390,008	90.00
91.00	Nursing Program cost	0	19,883,833	0.000000	4,138,541	0	91.00
92.00	Allied health cost	0	19,883,833	0.000000	4,138,541	0	92.00
93.00	All other Medical Education	0	19,883,833	0.000000	4,138,541	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 4/11/2024 3:17 pm

Title XIX | Subprovider - IPF | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,323	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,323	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)	4,323	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)	357	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)	816	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)	6,827,931	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)	6,827,931	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,827,931	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)	1,579.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	563,860	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)	563,860	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 4/11/2024 3:17 pm

Title XIX | Subprovider - IPF | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	27,179	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)	591,039	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 4/11/2024 3:17 pm
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description	1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
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	607,479	6,827,931	0.088970	0	0	90.00
91.00	Nursing Program cost	0	6,827,931	0.000000	0	0	91.00
92.00	Allied health cost	0	6,827,931	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,827,931	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 4/11/2024 3:17 pm

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,252	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,252	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)	6,252	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)	17	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)	816	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)	5,710,634	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)	5,710,634	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)	5,710,634	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)	913.41	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	15,528	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)	15,528	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 4/11/2024 3:17 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	23,769	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)	39,297	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 4/11/2024 3:17 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
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	694,440	5,710,634	0.121605	0	0	90.00
91.00	Nursing Program cost	0	5,710,634	0.000000	0	0	91.00
92.00	Allied health cost	0	5,710,634	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,710,634	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		8,220,511		30.00
31.00	03100	INTENSIVE CARE UNIT		5,171,709		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.191852	5,824,453	1,117,433	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.241635	427,611	103,326	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.447674	5,064	2,267	52.00
53.00	05300	ANESTHESIOLOGY	0.204357	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113632	7,593,466	862,861	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.220277	33,326	7,341	55.00
60.00	06000	LABORATORY	0.137538	8,744,772	1,202,738	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.326640	2,613,422	853,648	65.00
66.00	06600	PHYSICAL THERAPY	0.329782	2,812,793	927,609	66.00
69.00	06900	ELECTROCARDIOLOGY	0.149803	7,096,121	1,063,020	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.318867	34,184	10,900	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.497226	739,555	1,107,281	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.423445	1,596,093	675,858	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293027	5,616,702	1,645,845	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.183403	212	39	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.774977	409,165	317,093	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	FAMILY PRACTICE 120	0.000000		0	88.00
90.00	09000	CLINIC	3.292371	0	0	90.00
90.01	04950	WOUND CLINIC	0.318570	7,783	2,479	90.01
91.00	09100	EMERGENCY	0.217142	4,485,503	973,991	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.311073	2,003,004	623,080	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.514247	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		50,043,229	11,496,809	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		50,043,229		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF		948,536		40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.191852	12,660	2,429	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.241635	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.447674	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.204357	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113632	16,119	1,832	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.220277	0	0	55.00
60.00	06000	LABORATORY	0.137538	137,955	18,974	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.326640	25,379	8,290	65.00
66.00	06600	PHYSICAL THERAPY	0.329782	7,373	2,431	66.00
69.00	06900	ELECTROCARDIOLOGY	0.149803	11,463	1,717	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.318867	4,127	1,316	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.497226	1,845	2,762	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.423445	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293027	90,869	26,627	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.183403	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.774977	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	FAMILY PRACTICE 120	0.000000		0	88.00
90.00	09000	CLINIC	3.292371	0	0	90.00
90.01	04950	WOUND CLINIC	0.318570	0	0	90.01
91.00	09100	EMERGENCY	0.217142	169,069	36,712	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.311073	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.514247	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		476,859	103,090	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		476,859		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 4/11/2024 3:17 pm
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF		5,788,915		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.191852	20,176	3,871	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.241635	10,411	2,516	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.447674	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.204357	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113632	373,671	42,461	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.220277	0	0	55.00
60.00	06000	LABORATORY	0.137538	856,821	117,845	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.326640	837,151	273,447	65.00
66.00	06600	PHYSICAL THERAPY	0.329782	6,557,973	2,162,701	66.00
69.00	06900	ELECTROCARDIOLOGY	0.149803	79,630	11,929	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.318867	2,828	902	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.497226	90,696	135,792	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.423445	700	296	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293027	985,238	288,701	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.183403	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.774977	96,281	74,616	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	FAMILY PRACTICE 120	0.000000		0	88.00
90.00	09000	CLINIC	3.292371	0	0	90.00
90.01	04950	WOUND CLINIC	0.318570	0	0	90.01
91.00	09100	EMERGENCY	0.217142	93,257	20,250	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.311073	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.514247	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		10,004,833	3,135,327	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		10,004,833		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 4/11/2024 3:17 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		286,030		30.00
31.00	03100	INTENSIVE CARE UNIT		264,452		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		457,099		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.191816	248,928	47,748	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.241635	18,730	4,526	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.447674	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.204357	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113632	371,377	42,200	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.219524	7,699	1,690	55.00
60.00	06000	LABORATORY	0.136482	495,184	67,584	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.326640	150,677	49,217	65.00
66.00	06600	PHYSICAL THERAPY	0.329782	105,366	34,748	66.00
69.00	06900	ELECTROCARDIOLOGY	0.149784	201,226	30,140	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.317801	5,699	1,811	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.497226	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.423445	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293027	323,851	94,897	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.183162	7,874	1,442	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.774977	14,718	11,406	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	FAMILY PRACTICE 120	0.725224	0	0	88.00
90.00	09000	CLINIC	3.292371	20	66	90.00
90.01	04950	WOUND CLINIC	0.318570	1,069	341	90.01
91.00	09100	EMERGENCY	0.216597	330,209	71,522	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.311073	4,259	1,325	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.514247	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,286,886	460,663	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,286,886		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 4/11/2024 3:17 pm

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF		514,329		40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.191816	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.241635	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.447674	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.204357	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113632	15,094	1,715	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.219524	0	0	55.00
60.00	06000	LABORATORY	0.136482	33,988	4,639	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.326640	9,510	3,106	65.00
66.00	06600	PHYSICAL THERAPY	0.329782	8,324	2,745	66.00
69.00	06900	ELECTROCARDIOLOGY	0.149784	2,510	376	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.317801	735	234	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.497226	1,742	2,608	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.423445	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293027	38,338	11,234	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.183162	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.774977	674	522	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	FAMILY PRACTICE 120	0.725224	0	0	88.00
90.00	09000	CLINIC	3.292371	0	0	90.00
90.01	04950	WOUND CLINIC	0.318570	0	0	90.01
91.00	09100	EMERGENCY	0.216597	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.311073	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.514247	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		110,915	27,179	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		110,915		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 4/11/2024 3:17 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF		59,995		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.191816	186	36	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.241635	481	116	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.447674	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.204357	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113632	4,689	533	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.219524	0	0	55.00
60.00	06000	LABORATORY	0.136482	6,922	945	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.326640	2,127	695	65.00
66.00	06600	PHYSICAL THERAPY	0.329782	49,253	16,243	66.00
69.00	06900	ELECTROCARDIOLOGY	0.149784	894	134	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.317801	113	36	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.497226	1,783	2,670	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.423445	69	29	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293027	7,124	2,088	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.183162	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.774977	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	FAMILY PRACTICE 120	0.725224	0	0	88.00
90.00	09000	CLINIC	3.292371	0	0	90.00
90.01	04950	WOUND CLINIC	0.318570	767	244	90.01
91.00	09100	EMERGENCY	0.216597	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.311073	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.514247	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		74,408	23,769	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		74,408		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Hospital | PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	11,200,339	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,554,795	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	51,272	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	2.04
3.00	Managed Care Simulated Payments	6,742,802	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	90.90	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	39.58	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	39.58	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.435424	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.438511	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.435424	21.00
22.00	IME payment adjustment (see instructions)	3,140,276	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	1,435,044	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	3,140,276	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	1,435,044	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.25	30.00
31.00	Percentage of Medicaid patient days (see instructions)	18.82	31.00
32.00	Sum of lines 30 and 31	23.07	32.00
33.00	Allowable disproportionate share percentage (see instructions)	8.25	33.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 4/11/2024 3:17 pm
	Title XVIII	Hospital	PPS

Line	Description		1.00	
34.00	Disproportionate share adjustment (see instructions)		304,325	34.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	5,938,006,757	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000224628	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	1,611,996	1,333,843	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	1,205,684	335,283	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	1,540,967		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	19,791,974		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	18,406,092		48.00

Line	Description	Amount 1.00	
49.00	Total payment for inpatient operating costs (see instructions)	21,227,018	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,452,950	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	1,667,740	52.00
53.00	Nursing and Allied Health Managed Care payment	15,220	53.00
54.00	Special add-on payments for new technologies	8,048	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	41,826	58.00
59.00	Total (sum of amounts on lines 49 through 58)	24,412,802	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	24,412,802	61.00
62.00	Deductibles billed to program beneficiaries	1,916,008	62.00
63.00	Coinsurance billed to program beneficiaries	20,767	63.00
64.00	Allowable bad debts (see instructions)	122,662	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	79,730	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	22,908	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	22,555,757	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)	0	70.75
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-35,672	70.93
70.94	HRR adjustment amount (see instructions)	-71,273	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Hospital | PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		54,034	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		22,394,778	71.00
71.01	Sequestration adjustment (see instructions)		447,896	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		20,404,565	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		1,542,317	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		326,853	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	1.0000000000	0.9899650703	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.9951	0.9954	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	11,200,339	0	11,200,339		11,200,339	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,554,795	0		3,554,795	3,554,795	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	51,272	0	51,272		51,272	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	6,742,802	0	4,968,742	1,774,060	6,742,802	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.435424	0.435424	0.435424	0.435424		5.00
6.00	IME payment adjustment (see instructions)	22.00	3,140,276	0	2,383,723	756,553	3,140,276	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	1,435,044	0	1,057,478	377,566	1,435,044	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	3,140,276	0	2,383,723	756,553	3,140,276	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	1,435,044	0	1,057,478	377,566	1,435,044	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0825	0.0825	0.0825	0.0825		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	304,325	0	231,007	73,318	304,325	11.00
11.01	Uncompensated care payments	36.00	1,540,967	0	1,205,684	335,283	1,540,967	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	19,791,974	0	15,072,025	4,719,949	19,791,974	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	21,227,018	0	16,129,503	5,097,515	21,227,018	15.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,452,950	0	1,095,080	357,870	1,452,950	16.00
17.00	Special add-on payments for new technologies	54.00	8,048	0	8,048	0	8,048	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	17,232,631	5,455,385	22,688,016	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,107,849	0	833,986	273,863	1,107,849	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	9,423	0	8,396	1,027	9,423	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.3030	0.3030	0.3030	0.3030		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	335,678	0	252,698	82,980	335,678	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,452,950	0	1,095,080	357,870	1,452,950	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	11,200,339	11,200,339		11,200,339	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,554,795		3,554,795	3,554,795	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	51,272	51,272		51,272	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	6,742,802	4,968,742	1,774,060	6,742,802	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.435424	0.435424	0.435424		5.00
6.00	IME payment adjustment (see instructions)	22.00	3,140,276	2,383,723	756,553	3,140,276	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	1,435,044	1,057,478	377,566	1,435,044	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	3,140,276	2,383,723	756,553	3,140,276	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	1,435,044	1,057,478	377,566	1,435,044	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0825	0.0825	0.0825		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	304,325	231,007	73,318	304,325	11.00
11.01	Uncompensated care payments	36.00	1,540,967	1,205,684	335,283	1,540,967	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	19,791,974	15,072,025	4,719,949	19,791,974	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	21,227,018	16,129,503	5,097,515	21,227,018	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,452,950	1,095,080	357,870	1,452,950	16.00
17.00	Special add-on payments for new technologies	54.00	8,048	8,048	0	8,048	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			17,232,631	5,455,385	22,688,016	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Exhibit 5 Date/Time Prepared: 4/11/2024 3:17 pm
	Title XVIII	Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,107,849	833,986	273,863	1,107,849	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	9,423	8,396	1,027	9,423	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.3030	0.3030	0.3030		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	335,678	252,698	82,980	335,678	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,452,950	1,095,080	357,870	1,452,950	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-35,672	0	-35,672	-35,672	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-71,273	-54,921	-16,352	-71,273	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	54,034	54,034	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part B Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,218	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	31,510,651	2.00
3.00	OPPS or REH payments	28,512,723	3.00
4.00	Outlier payment (see instructions)	1,997	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	34,394	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,218	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	11,027	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	11,027	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	11,027	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	7,809	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	3,218	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	28,549,114	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,390,481	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	23,161,851	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	1,701,438	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	24,863,289	30.00
31.00	Primary payer payments	7,071	31.00
32.00	Subtotal (line 30 minus line 31)	24,856,218	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	299,570	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	194,721	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	154,566	36.00
37.00	Subtotal (see instructions)	25,050,939	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-71	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	25,051,010	40.00
40.01	Sequestration adjustment (see instructions)	501,020	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	24,442,288	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	107,702	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 4/11/2024 3:17 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 4/11/2024 3:17 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	63	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	962	2.00
3.00	OPPS or REH payments	2,509	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	2	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	63	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	215	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	215	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	215	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	152	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	63	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	2,511	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	441	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,133	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	2,133	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,133	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	1,556	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	1,011	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	3,144	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,144	40.00
40.01	Sequestration adjustment (see instructions)	63	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	2,093	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	988	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 4/11/2024 3:17 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 4/11/2024 3:17 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	285	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,220	2.00
3.00	OPPS or REH payments	482	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	285	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	974	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	974	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	974	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	689	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	285	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	482	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	12	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	755	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	755	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	755	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	755	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	755	40.00
40.01	Sequestration adjustment (see instructions)	15	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	775	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-35	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 4/11/2024 3:17 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I Date/Time Prepared: 4/11/2024 3:17 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		18,672,881		22,656,670	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	09/06/2023	367,100	12/31/2023	1,345,918	3.01
3.02		12/31/2023	1,364,584	09/06/2023	439,700	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		1,731,684		1,785,618	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)		20,404,565		24,442,288	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		1,542,317		107,702	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		21,946,882		24,549,990	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Subprovider - IPF | 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		518,984		2,093	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		518,984		2,093	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		13,941		988	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		532,925		3,081	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Subprovider - IRF | 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		7,687,812		775	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7,687,812		775	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		713		35	6.02
7.00	Total Medicare program liability (see instructions)		7,687,099		740	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 4/11/2024 3:17 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-3 Part II | Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Subprovider - IPF | PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	536,349	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	2,301	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	3.98	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	3.98	8.00
9.00	Average Daily Census (see instructions)	11.843836	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.160906	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	86,302	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	624,952	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	624,952	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	624,952	18.00
19.00	Deductibles	86,356	19.00
20.00	Subtotal (line 18 minus line 19)	538,596	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	538,596	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	6,993	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	4,545	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,462	25.00
26.00	Subtotal (sum of lines 22 and 24)	543,141	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	Other pass through costs (see instructions)	660	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.98	Recovery of accelerated depreciation.	0	30.98
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	543,801	31.00
31.01	Sequestration adjustment (see instructions)	10,876	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	518,984	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	13,941	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	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	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)		
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.160906	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part III Date/Time Prepared: 4/11/2024 3:17 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	7,661,357	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0225	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	144,034	3.00
4.00	Outlier Payments	106,520	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	17.128767	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	7,911,911	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	7,911,911	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	7,911,911	19.00
20.00	Deductibles	67,200	20.00
21.00	Subtotal (line 19 minus line 20)	7,844,711	21.00
22.00	Coinsurance	10,800	22.00
23.00	Subtotal (line 21 minus line 22)	7,833,911	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	9,184	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	5,970	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,600	26.00
27.00	Subtotal (sum of lines 23 and 25)	7,839,881	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	4,098	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.98	Recovery of accelerated depreciation.	0	31.98
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	7,843,979	32.00
32.01	Sequestration adjustment (see instructions)	156,880	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	7,687,812	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-713	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	106,520	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	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)		
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-3 Part VII Date/Time Prepared: 4/11/2024 3:17 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	1,117,188		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)	1,117,188	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)	1,117,188	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	1,007,581		8.00
9.00	Ancillary service charges	2,286,886	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)	3,294,467	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)	3,294,467	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	2,177,279	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)	1,117,188	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)	1,117,188	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)	1,117,188	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	1,117,188	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	1,117,188	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)	1,117,188	0	40.00
41.00	Interim payments	1,496,448	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-379,260	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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-3 Part VII | Date/Time Prepared: 4/11/2024 3:17 pm

Title XIX | Subprovider - IPF | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	591,039		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)	591,039	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)	591,039	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	514,329		8.00
9.00	Ancillary service charges	110,915	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)	625,244	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)	625,244	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	34,205	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)	591,039	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)	591,039	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)	591,039	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	591,039	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	591,039	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)	591,039	0	40.00
41.00	Interim payments	291,834	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	299,205	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

CALCULATION OF REIMBURSEMENT SETTLEMENT

	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 4/11/2024 3:17 pm
	Title XIX	Subprovider - IRF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	39,297		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)	39,297	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)	39,297	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	59,995		8.00
9.00	Ancillary service charges	74,408	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)	134,403	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)	134,403	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	95,106	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)	39,297	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)	39,297	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)	39,297	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	39,297	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	39,297	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)	39,297	0	40.00
41.00	Interim payments	50,582	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-11,285	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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet E-4 Date/Time Prepared: 4/11/2024 3:17 pm
	Title XVIII	Hospital	PPS

		1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT		
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.	0.00	1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)	0.00	1.01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)	0.00	2.00
2.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	2.26
3.00	Amount of reduction to Direct GME cap under section 422 of MMA	0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)	0.00	3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	3.02
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)	0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)	0.00	4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	4.21
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27	0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)	0.00	6.00
7.00	Enter the lesser of line 5 or line 6	0.00	7.00

		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	24.87	18.22		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	25.09	18.47		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	24.87	18.22		17.00
18.00	Per resident amount	126,519.57	126,519.57		18.00
18.01	Per resident amount under §131 of the CAA 2021	0.00	0.00		18.01
19.00	Approved amount for resident costs	3,146,542	2,305,187	5,451,729	19.00

		1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)	0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)	0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)	0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)	0.00	23.00
24.00	Multiply line 22 time line 23	0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)	5,451,729	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-4 | Date/Time Prepared: 4/11/2024 3:17 pm

Title XVIII | Hospital | PPS

		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	11,595	4,607		26.00
27.00	Total Inpatient Days (see instructions)	25,973	25,973		27.00
28.00	Ratio of inpatient days to total inpatient days	0.446425	0.177377		28.00
29.00	Program direct GME amount	2,433,788	967,011	3,400,799	29.00
29.01	Percent reduction for MA DGME		3.27		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		31,621	31,621	30.00
31.00	Net Program direct GME amount			3,369,178	31.00

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	30,920,897	37.00
38.00	Organ acquisition and HSCT acquisition costs (see instructions)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	30,920,897	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	31,552,795	42.00
43.00	Primary payer payments (see instructions)	7,071	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	31,545,724	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	62,466,621	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.494999	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.505001	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	3,369,178	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	1,667,740	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	1,701,438	50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 4/11/2024 3:17 pm
	Title XVIII		PPS

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 4/11/2024 3:17 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	9,836,656	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	85,557,266	0	0	0	4.00
5.00	Other receivable	10,862,706	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-53,765,157	0	0	0	6.00
7.00	Inventory	2,862,111	0	0	0	7.00
8.00	Prepaid expenses	6,780,863	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	62,134,445	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	6,581,448	0	0	0	12.00
13.00	Land improvements	10,854,720	0	0	0	13.00
14.00	Accumulated depreciation	-8,008,840	0	0	0	14.00
15.00	Buildings	177,946,557	0	0	0	15.00
16.00	Accumulated depreciation	-96,690,066	0	0	0	16.00
17.00	Leasehold improvements	479,187	0	0	0	17.00
18.00	Accumulated depreciation	-388,297	0	0	0	18.00
19.00	Fixed equipment	118,340,313	0	0	0	19.00
20.00	Accumulated depreciation	-74,563,196	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	111,449,542	0	0	0	23.00
24.00	Accumulated depreciation	-97,287,930	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)	148,713,438	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	81,967,631	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	6,969,298	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	88,936,929	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	299,784,812	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,730,130	0	0	0	37.00
38.00	Salaries, wages, and fees payable	11,939,837	0	0	0	38.00
39.00	Payroll taxes payable	-35,742	0	0	0	39.00
40.00	Notes and loans payable (short term)	5,801,744	0	0	0	40.00
41.00	Deferred income	72,147	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	449,752	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	19,957,868	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	101,384,447	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-250,957	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	101,133,490	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	121,091,358	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	178,693,454				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	178,693,454	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	299,784,812	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 4/11/2024 3:17 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		178,023,603		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,584,746				2.00
3.00	Total (sum of line 1 and line 2)		176,438,857		0		3.00
4.00	Additions	2,254,597		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		2,254,597		0		10.00
11.00	Subtotal (line 3 plus line 10)		178,693,454		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)		178,693,454		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		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 4/11/2024 3:17 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	29,234,656		29,234,656	1.00
2.00	SUBPROVIDER - IPF	8,421,632		8,421,632	2.00
3.00	SUBPROVIDER - IRF	7,986,955		7,986,955	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)	45,643,243		45,643,243	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	13,374,768		13,374,768	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)	13,374,768		13,374,768	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	59,018,011		59,018,011	17.00
18.00	Ancillary services	117,036,844	396,942,400	513,979,244	18.00
19.00	Outpatient services	12,241,303	54,464,979	66,706,282	19.00
20.00	FAMILY PRACTICE 120	60,807	3,347,168	3,407,975	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	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	0	1,644,072	1,644,072	26.00
27.00	DME	0	455,308	455,308	27.00
27.01	PHYSICIAN OFFICE	1,834,673	49,761,295	51,595,968	27.01
27.02	PROFESSIONAL FEES	4,114,076	18,933,786	23,047,862	27.02
27.03	DIETARY REVENUE	0	790,746	790,746	27.03
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	194,305,714	526,339,754	720,645,468	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		273,083,424		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		273,083,424		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 4/11/2024 3:17 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	720,645,468	1.00
2.00	Less contractual allowances and discounts on patients' accounts	475,716,411	2.00
3.00	Net patient revenues (line 1 minus line 2)	244,929,057	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	273,083,424	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-28,154,367	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	4,420,489	23.00
24.00	OTHER OPERATING INCOME	6,421,597	24.00
24.01	INTEREST INCOME & DISTRIBUTIONS	9,290,941	24.01
24.02	OTHER INCOME	2,058,785	24.02
24.03	OTHER NONOPERATING INCOME	1,106,405	24.03
24.04	UNREALIZED GAIN/LOSS ON INVESTMENTS	2,100,000	24.04
24.05	OTHER REVENUE	41,978	24.05
24.50	COVID-19 PHE Funding	1,129,426	24.50
25.00	Total other income (sum of lines 6-24)	26,569,621	25.00
26.00	Total (line 5 plus line 25)	-1,584,746	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,584,746	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O | Date/Time Prepared: 4/11/2024 3:17 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	156,850	156,850	0	156,850	3.00
4.00	ADMINISTRATIVE & GENERAL*	61,870	280,600	342,470	-156,850	185,620	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	9,943	9,943	0	9,943	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	51,541	51,541	0	51,541	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	26	26	0	26	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	19,068	24,014	43,082	0	43,082	26.00
27.00	NURSE PRACTITIONER**	5,016	0	5,016	0	5,016	27.00
28.00	REGISTERED NURSE**	245,111	0	245,111	0	245,111	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	128,880	0	128,880	0	128,880	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	55,746	0	55,746	0	55,746	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	515,691	522,974	1,038,665	-156,850	881,815	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O | Date/Time Prepared: 4/11/2024 3:17 pm

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	156,850	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	185,620	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	9,943	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	51,541	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	26	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	43,082	26.00
27.00	NURSE PRACTITIONER**	0	5,016	27.00
28.00	REGISTERED NURSE**	0	245,111	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	128,880	33.00
34.00	SPIRITUAL COUNSELING**	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	55,746	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
	NONREIMBURSABLE COST CENTERS			
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	0	881,815	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE	Provider CCN: 15-0042 Hospice CCN: 15-1526	Period: From 01/01/2023 To 12/31/2023	Worksheet O-2 Date/Time Prepared: 4/11/2024 3:17 pm
		Hospice I	

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	18,182	0	18,182	0	18,182	26.00
27.00	NURSE PRACTITIONER	4,783	0	4,783	0	4,783	27.00
28.00	REGISTERED NURSE	233,727	0	233,727	0	233,727	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	122,895	0	122,895	0	122,895	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	53,157	0	53,157	0	53,157	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	432,744	0	432,744	0	432,744	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	18,182	26.00
27.00	NURSE PRACTITIONER	0	4,783	27.00
28.00	REGISTERED NURSE	0	233,727	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	122,895	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	53,157	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	432,744	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPITE CARE

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-3 | Date/Time Prepared: 4/11/2024 3:17 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	26	0	26	0	26	26.00
27.00	NURSE PRACTITIONER	7	0	7	0	7	27.00
28.00	REGISTERED NURSE	333	0	333	0	333	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	175	0	175	0	175	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	76	0	76	0	76	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	617	0	617	0	617	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	26	26.00
27.00	NURSE PRACTITIONER	0	7	27.00
28.00	REGISTERED NURSE	0	333	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	175	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	76	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	617	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-4 | Date/Time Prepared: 4/11/2024 3:17 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	860	24,014	24,874	0	24,874	26.00
27.00	NURSE PRACTITIONER	226	0	226	0	226	27.00
28.00	REGISTERED NURSE	11,051	0	11,051	0	11,051	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	5,810	0	5,810	0	5,810	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	2,513	0	2,513	0	2,513	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	20,460	24,014	44,474	0	44,474	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	24,874	26.00
27.00	NURSE PRACTITIONER	0	226	27.00
28.00	REGISTERED NURSE	0	11,051	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	5,810	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	2,513	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	44,474	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-5 | Date/Time Prepared: 4/11/2024 3:17 pm

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	111,600	111,600	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	220	220	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	156,850	156,505	313,355	3.00
4.00	ADMINISTRATIVE & GENERAL	185,620	145,391	331,011	4.00
5.00	PLANT OPERATION & MAINTENANCE	9,943	131,616	141,559	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	66,321	66,321	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	126,405	126,405	9.00
10.00	ROUTINE MEDICAL SUPPLIES	51,541	847	52,388	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	26	6	32	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	432,744		432,744	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	617		617	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	44,474		44,474	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	881,815	738,911	1,620,726	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-6 Part I | Date/Time Prepared: 4/11/2024 3:17 pm

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	111,600	111,600				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	220		220			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	313,355	0	0	313,355		3.00
4.00	ADMINISTRATIVE & GENERAL	331,011	0	0	0	331,011	4.00
5.00	PLANT OPERATION & MAINTENANCE	141,559	0	0	0	141,559	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	66,321	0	0	0	66,321	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	126,405	0	0	0	126,405	9.00
10.00	ROUTINE MEDICAL SUPPLIES	52,388	0	0	0	52,388	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	32	0	0	0	32	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	432,744			298,802	731,546	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	617	2,013	4	426	3,060	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	44,474	109,587	216	14,127	168,404	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	1,620,726	111,600	220	313,355	1,620,726	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-6 Part I | Date/Time Prepared: 4/11/2024 3:17 pm

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	331,011					4.00
5.00	PLANT OPERATION & MAINTENANCE	36,332	177,891				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	17,022	0		83,343		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	32,442	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	13,446	0		0		10.00
11.00	MEDICAL RECORDS	0	0		0		11.00
12.00	STAFF TRANSPORTATION	0	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	8	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	187,754					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	785	3,209	0	1,504	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	43,222	174,682	0	81,839	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	331,011	177,891	0	83,343	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-6 Part I | Date/Time Prepared: 4/11/2024 3:17 pm

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	158,847					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	65,834				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	151,469	62,777	0	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	214	89	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	7,164	2,968	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	158,847	65,834	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-6 Part I | Date/Time Prepared: 4/11/2024 3:17 pm

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	40					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	38	0	0		1,133,584	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	8,861	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	2	0	0	0	478,281	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	40	0	0	0	1,620,726	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-6 Part II | Date/Time Prepared: 4/11/2024 3:17 pm

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	388					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		388				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	513,668			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-331,011	1,289,715	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	141,559	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	66,321	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	126,405	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	52,388	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	32	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			489,812	0	731,546	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	7	7	698	0	3,060	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	381	381	23,158	0	168,404	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	111,600	220	313,355		331,011	100.00
101.00	UNIT COST MULTIPLIER	287.628866	0.567010	0.610034		0.256654	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-6 Part II | Date/Time Prepared: 4/11/2024 3:17 pm

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	388					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		388			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		16,297	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					15,540	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	7	0	7	0	22	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	381	0	381	0	735	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	177,891	0	83,343	0	158,847	100.00
101.00	UNIT COST MULTIPLIER	458.481959	0.000000	214.801546	0.000000	9.747009	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-6 Part II
Hospice CCN: 15-1526 | Date/Time Prepared: 4/11/2024 3:17 pm

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	3,682					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	6,107	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	3,511	0	0	0	5,824	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	5	0	0	0	8	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	166	0	0	0	275	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	65,834	0	0	0	40	100.00
101.00	UNIT COST MULTIPLIER	17.879957	0.000000	0.000000	0.000000	0.006550	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-6 Part II | Date/Time Prepared: 4/11/2024 3:17 pm

Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	
		15.00	16.00	17.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT				1.00
2.00	CAP REL COSTS-MVBLE EQUIP				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT				3.00
4.00	ADMINISTRATIVE & GENERAL				4.00
5.00	PLANT OPERATION & MAINTENANCE				5.00
6.00	LAUNDRY & LINEN SERVICE				6.00
7.00	HOUSEKEEPING				7.00
8.00	DIETARY				8.00
9.00	NURSING ADMINISTRATION				9.00
10.00	ROUTINE MEDICAL SUPPLIES				10.00
11.00	MEDICAL RECORDS				11.00
12.00	STAFF TRANSPORTATION				12.00
13.00	VOLUNTEER SERVICE COORDINATION				13.00
14.00	PHARMACY				14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			15.00
16.00	OTHER GENERAL SERVICE		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0		51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM		0		60.00
61.00	VOLUNTEER PROGRAM		0		61.00
62.00	FUNDRAISING		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0		63.00
64.00	PALLIATIVE CARE PROGRAM		0		64.00
65.00	OTHER PHYSICIAN SERVICES		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING		0		67.00
68.00	TELEHEALTH/TELEMONITORING		0		68.00
69.00	THRIFT STORE		0		69.00
70.00	NURSING FACILITY ROOM & BOARD				70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER				99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000	101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-7 | Date/Time Prepared: 4/11/2024 3:17 pm

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.329782	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.293027	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0.514247	0	0	0	5.00
6.00	LABORATORY	60.00	0.136482	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	1.497226	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.219524	0	0	0	9.00
10.00	MH ANCILLARY OUTPATIENT	76.00	0.000000	0	0	0	10.00
10.01	INPATIENT DIALYSIS	76.01	0.774977	0	0	0	10.01
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	9.00
10.00	MH ANCILLARY OUTPATIENT	0	0	0	0	0	10.00
10.01	INPATIENT DIALYSIS	0	0	0	0	0	10.01
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Provider CCN: 15-0042 Hospice CCN: 15-1526	Period: From 01/01/2023 To 12/31/2023	Worksheet O-8 Date/Time Prepared: 4/11/2024 3:17 pm
		Hospice I	

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			1,133,584	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			3,511	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			322.87	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	3,274	181		9.00
10.00	Program cost (line 8 times line 9)	1,057,076	58,439		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			8,861	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			5	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			1,772.20	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	5	0		14.00
15.00	Program cost (line 13 times line 14)	8,861	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			478,281	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			166	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			2,881.21	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	166	0		19.00
20.00	Program cost (line 18 times line 19)	478,281	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,620,726	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			3,682	22.00
23.00	Average cost per diem (line 21 divided by line 22)			440.18	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 4/11/2024 3:17 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,107,849	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	9,423	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	42.19	3.00
4.00	Number of interns & residents (see instructions)	39.58	4.00
5.00	Indirect medical education percentage (see instructions)	30.30	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	335,678	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	1,452,950	12.00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00

		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0042 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1

Component CCN: 15-8577 | Date/Time Prepared: 4/11/2024 3:17 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	8,977	137	9,114	0	9,114	1.00
2.00	Physician Assistant	2,283	0	2,283	0	2,283	2.00
3.00	Nurse Practitioner	1,993	0	1,993	0	1,993	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	6,695	0	6,695	0	6,695	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	19,948	137	20,085	0	20,085	10.00
11.00	Physician Services Under Agreement	0	1,850	1,850	0	1,850	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	1,850	1,850	0	1,850	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	19,948	1,987	21,935	0	21,935	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	173	173	0	173	29.00
30.00	Administrative Costs	1,889	444,714	446,603	-444,404	2,199	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,889	444,887	446,776	-444,404	2,372	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	21,837	446,874	468,711	-444,404	24,307	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-0042 Component CCN: 15-8577	Period: From 01/01/2023 To 12/31/2023	Worksheet M-1 Date/Time Prepared: 4/11/2024 3:17 pm
		RHC I	Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	9,114	1.00
2.00	Physician Assistant	0	2,283	2.00
3.00	Nurse Practitioner	0	1,993	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	6,695	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
7.10	Marriage and Family Therapist			7.10
7.11	Mental Health Counselor			7.11
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	20,085	10.00
11.00	Physician Services Under Agreement	0	1,850	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	1,850	14.00
15.00	Medical Supplies	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	21,935	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	173	29.00
30.00	Administrative Costs	0	2,199	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	2,372	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	24,307	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0042 Component CCN: 15-8577	Period: From 01/01/2023 To 12/31/2023	Worksheet M-2 Date/Time Prepared: 4/11/2024 3:17 pm
		RHC I	Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.04	0	4,200	168		1.00
2.00	Physician Assistant	0.01	6	2,100	21		2.00
3.00	Nurse Practitioner	0.01	0	2,100	21		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.06	6		210	210	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.06	6			210	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	21,935	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	21,935	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	2,372	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	9,553	15.00
16.00	Total overhead (sum of lines 14 and 15)	11,925	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	11,925	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	11,925	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	33,860	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0042 Component CCN: 15-8577	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 4/11/2024 3:17 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		33,860	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		33,860	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		210	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		210	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		161.24	7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	126.00	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	126.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	0	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		0	16.04
16.05	Total program cost (see instructions)	0	0	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		0	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		0	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		0	26.00
26.01	Sequestration adjustment (see instructions)		0	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		0	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		0	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00