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: 15-4021	Period: From 07/01/2022 To 06/30/2023	Worksheet S Parts I-III Date/Time Prepared: 11/30/2023 10:22 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/30/2023 Time: 10:22 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GRANT BLACKFORD MENTAL HEALTH, INC. (15-4021) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	*Jonda Manwell*		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	Jonda Manwell			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	7,531	4,560	0	-47,365	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	7,531	4,560	0	-47,365	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: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/30/2023 10:22 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 505 WABASH AVENUE	PO Box:			1.00
2.00	City: MARION	State: IN	Zip Code: 46952	County:	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	GRANT BLACKFORD MENTAL HEALTH, INC.	154021	99915	4	08/12/1982	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2022	06/30/2023	20.00
21.00	Type of Control (see instructions)	2		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/30/2023 10:22 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/30/2023 10:22 am

		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.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/30/2023 10:22 am

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

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	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	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	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.		0	88.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/30/2023 10:22 am

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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	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.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/30/2023 10:22 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	73,446	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.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	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?	N	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: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/30/2023 10:22 am

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

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

				1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act				
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)				168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00	169.00
		Beginning	Ending		
		1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				170.00
		1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 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: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/30/2023 10:22 am

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	08/07/2023	Y	08/07/2023	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: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/30/2023 10:22 am

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

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA	SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946	TSEVERS@BLUEANDCO.COM	43.00

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 11/30/2023 10:22 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	16	5,840	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)		16	5,840	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		16	5,840	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		16				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: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/30/2023 10:22 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	153	140	2,056			1.00
2.00	HMO and other (see instructions)	0	415				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	153	140	2,056			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)	153	140	2,056	0.00	203.69	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	203.69	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	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: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/30/2023 10:22 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	34	45	696	1.00
2.00	HMO and other (see instructions)			0	133		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	34	45	696	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/30/2023 10:22 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		651,049	651,049	0	651,049	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	147,110	215,602	362,712	0	362,712	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,336,842	3,559,818	7,896,660	0	7,896,660	5.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,300,187	1,691,897	2,992,084	-11	2,992,073	30.00
	ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	0	21,727	21,727	0	21,727	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	117,361	117,361	0	117,361	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	7,210,249	4,307,378	11,517,627	-969,709	10,547,918	90.00
	OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,994,388	10,564,832	23,559,220	-969,720	22,589,500	118.00
	NONREIMBURSABLE COST CENTERS							
194.00	07950	RESIDENTIAL	1,875,108	1,441,619	3,316,727	969,720	4,286,447	194.00
194.01	07951	OTHER NONREIMBURSABLE	298,211	525,436	823,647	0	823,647	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	15,167,707	12,531,887	27,699,594	0	27,699,594	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/30/2023 10:22 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	651,049		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-30	362,682		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,058,750	6,837,910		5.00
7.00	00700	OPERATION OF PLANT	0	0		7.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-295	2,991,778		30.00
		ANCILLARY SERVICE COST CENTERS				
60.00	06000	LABORATORY	0	21,727		60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	117,361		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-50,753	10,497,165		90.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,109,828	21,479,672		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	RESIDENTIAL	0	4,286,447		194.00
194.01	07951	OTHER NONREIMBURSABLE	0	823,647		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,109,828	26,589,766		200.00

RECLASSIFICATIONS | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/30/2023 10:22 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - MRO RECLASS					
1.00	RESIDENTIAL	194.00	607,061	362,659		1.00
2.00		0.00	0	0		2.00
	TOTALS		607,061	362,659		
500.00	Grand Total: Increases		607,061	362,659		500.00

RECLASSIFICATIONS | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/30/2023 10:22 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - MRO RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	5	6	0		1.00
2.00	CLINIC	90.00	607,056	362,653	0		2.00
	TOTALS		607,061	362,659			
500.00	Grand Total: Decreases		607,061	362,659			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 11/30/2023 10:22 am

		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	417,947	20,290	0	20,290	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	6,701,260	1,415,391	0	1,415,391	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,436,712	251,868	0	251,868	0	5.00
6.00	Movable Equipment	735,731	32,511	0	32,511	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	10,291,650	1,720,060	0	1,720,060	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	10,291,650	1,720,060	0	1,720,060	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	438,237	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	8,116,651	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	2,688,580	0	5.00
6.00	Movable Equipment	768,242	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	12,011,710	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	12,011,710	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part II Date/Time Prepared: 11/30/2023 10:22 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	651,049	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	651,049	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	651,049		1.00
3.00	Total (sum of lines 1-2)	0	651,049		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 11/30/2023 10:22 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	12,011,710	0	12,011,710	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	12,011,710	0	12,011,710	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	651,049	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	651,049	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	651,049	1.00
3.00	Total (sum of lines 1-2)	0	0	0	0	651,049	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/30/2023 10:22 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	0			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		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/30/2023 10:22 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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	HAF EXPENSE	A	-941,989	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	PAYEE INCOME	B	-40,057	CLINIC	90.00	0	33.01
33.02	CAFETERIA REVENUE	B	-10	CLINIC	90.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-30	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-61,409	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-9,121	CLINIC	90.00	0	33.05
33.06	SPONSORSHIP	A	-1,976	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	SPONSORSHIP	A	-286	ADULTS & PEDIATRICS	30.00	0	33.07
33.08	SPONSORSHIP	A	-310	CLINIC	90.00	0	33.08
33.09	INTEREST INCOME	B	-23,710	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	ADVERTISING	A	-29,416	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	TRAINING REVENUE	B	-250	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	AGENCY PROMOTIONAL OFFSET	A	-9	ADULTS & PEDIATRICS	30.00	0	33.12
33.13	AGENCY PROMOTIONAL OFFSET	A	-1,255	CLINIC	90.00	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,109,828				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.

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/30/2023 10:22 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	651,049	651,049				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	362,682	0	362,682			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,837,910	180,371	104,717	7,122,998	7,122,998	5.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,991,778	62,847	31,394	3,086,019	1,129,193	30.00
	ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	21,727	0	0	21,727	7,950	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	117,361	0	0	117,361	42,943	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	10,497,165	233,531	159,436	10,890,132	3,984,756	90.00
	OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,479,672	476,749	295,547	21,238,237	5,164,842	118.00
	NONREIMBURSABLE COST CENTERS							
194.00	07950	RESIDENTIAL	4,286,447	174,300	59,934	4,520,681	1,654,144	194.00
194.01	07951	OTHER NONREIMBURSABLE	823,647	0	7,201	830,848	304,012	194.01
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)	26,589,766	651,049	362,682	26,589,766	7,122,998	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/30/2023 10:22 am

		Cost Center Description	OPERATION OF PLANT	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			7.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	0					7.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	4,215,212	0	4,215,212	30.00
		ANCILLARY SERVICE COST CENTERS						
60.00	06000	LABORATORY	0	0	29,677	0	29,677	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	160,304	0	160,304	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	14,874,888	0	14,874,888	90.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	19,280,081	0	19,280,081	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	RESIDENTIAL	0	0	6,174,825	0	6,174,825	194.00
194.01	07951	OTHER NONREIMBURSABLE	0	0	1,134,860	0	1,134,860	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	26,589,766	0	26,589,766	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/30/2023 10:22 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	180,371	180,371	0	180,371	5.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	62,847	62,847	0	28,595	30.00
		ANCILLARY SERVICE COST CENTERS						
60.00	06000	LABORATORY	0	0	0	0	201	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,087	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	233,531	233,531	0	100,900	90.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	476,749	476,749	0	130,783	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	RESIDENTIAL	0	174,300	174,300	0	41,889	194.00
194.01	07951	OTHER NONREIMBURSABLE	0	0	0	0	7,699	194.01
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	651,049	651,049	0	180,371	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/30/2023 10:22 am

		Cost Center Description	OPERATION OF PLANT	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			7.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	0					7.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	91,442	0	91,442	30.00
		ANCILLARY SERVICE COST CENTERS						
60.00	06000	LABORATORY	0	0	201	0	201	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,087	0	1,087	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	334,431	0	334,431	90.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	427,161	0	427,161	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	RESIDENTIAL	0	0	216,189	0	216,189	194.00
194.01	07951	OTHER NONREIMBURSABLE	0	0	7,699	0	7,699	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	651,049	0	651,049	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/30/2023 10:22 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	104,235					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	15,020,597				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,878	4,336,842	-7,122,998	19,466,768		5.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	75,357	7.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,062	1,300,182	0	3,086,019	10,062	30.00
		ANCILLARY SERVICE COST CENTERS						
60.00	06000	LABORATORY	0	0	0	21,727	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	117,361	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	37,389	6,603,193	0	10,890,132	37,389	90.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	76,329	12,240,217	-7,122,998	14,115,239	47,451	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	RESIDENTIAL	27,906	2,482,169	0	4,520,681	27,906	194.00
194.01	07951	OTHER NONREIMBURSABLE	0	298,211	0	830,848	0	194.01
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)	651,049	362,682		7,122,998	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.245973	0.024146		0.365906	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		0		180,371	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000000		0.009266	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/30/2023 10:22 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS SALARIES)		
			16.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0		30.00
		ANCILLARY SERVICE COST CENTERS			
60.00	06000	LABORATORY	0		60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		77.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	RESIDENTIAL	0		194.00
194.01	07951	OTHER NONREIMBURSABLE	0		194.01
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/30/2023 10:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,215,212		4,215,212	0	4,215,212	30.00
		ANCILLARY SERVICE COST CENTERS						
60.00	06000	LABORATORY	29,677		29,677	0	29,677	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	160,304		160,304	0	160,304	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	14,874,888		14,874,888	0	14,874,888	90.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	19,280,081	0	19,280,081	0	19,280,081	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	19,280,081	0	19,280,081	0	19,280,081	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/30/2023 10:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,652,696		4,652,696			30.00
		ANCILLARY SERVICE COST CENTERS						
60.00	06000	LABORATORY	35,433	0	35,433	0.837553	0.000000	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	191,394	0	191,394	0.837560	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,776,043	914,790	3,690,833	4.030225	0.000000	90.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	7,655,566	914,790	8,570,356			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,655,566	914,790	8,570,356			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/30/2023 10:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS			30.00
	ANCILLARY SERVICE COST CENTERS				
60.00	06000	LABORATORY	0.837553		60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.837560		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	4.030225		90.00
	OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/30/2023 10:22 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,215,212		4,215,212	0	4,215,212	30.00
		ANCILLARY SERVICE COST CENTERS						
60.00	06000	LABORATORY	29,677		29,677	0	29,677	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	160,304		160,304	0	160,304	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	14,874,888		14,874,888	0	14,874,888	90.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	19,280,081	0	19,280,081	0	19,280,081	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	19,280,081	0	19,280,081	0	19,280,081	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/30/2023 10:22 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,652,696		4,652,696			30.00
		ANCILLARY SERVICE COST CENTERS						
60.00	06000	LABORATORY	35,433	0	35,433	0.837553	0.000000	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	191,394	0	191,394	0.837560	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,776,043	914,790	3,690,833	4.030225	0.000000	90.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	7,655,566	914,790	8,570,356			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,655,566	914,790	8,570,356			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/30/2023 10:22 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS			30.00
	ANCILLARY SERVICE COST CENTERS				
60.00	06000	LABORATORY	0.000000		60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000		90.00
	OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part I Date/Time Prepared: 11/30/2023 10:22 am

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	91,442	0	91,442	2,056	44.48	30.00
200.00	Total (lines 30 through 199)	91,442		91,442	2,056		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	153	6,805	30.00
200.00	Total (lines 30 through 199)	153	6,805	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 11/30/2023 10:22 am

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							
60.00	06000	LABORATORY	201	35,433	0.005673	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,087	191,394	0.005679	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	334,431	3,690,833	0.090611	0	0	90.00
200.00		Total (lines 50 through 199)	335,719	3,917,660		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part III Date/Time Prepared: 11/30/2023 10:22 am

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
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	2,056	0.00	153	30.00
200.00		Total (lines 30 through 199)		0	2,056		153	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/30/2023 10:22 am

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						
60.00	06000	LABORATORY	0	0	0	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/30/2023 10:22 am

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							
60.00	06000	LABORATORY	0	0	0	35,433	0.000000	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	191,394	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	3,690,833	0.000000	90.00
200.00		Total (lines 50 through 199)	0	0	0	3,917,660		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/30/2023 10:22 am

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							
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	70,200	0	90.00
200.00		Total (lines 50 through 199)		0	0	70,200	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/30/2023 10:22 am

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							
60.00	06000	LABORATORY	0.837553	0	0	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.837560	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	4.030225	70,200	0	0	282,922	90.00
200.00		Subtotal (see instructions)		70,200	0	0	282,922	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		70,200	0	0	282,922	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/30/2023 10:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
60.00	06000	LABORATORY	0	0		60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/30/2023 10:22 am

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)	2,056	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,056	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,056	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)	153	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)	4,215,212	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)	4,215,212	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)	4,215,212	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,050.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	313,681	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)	313,681	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/30/2023 10:22 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	313,681	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)	6,805	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)	6,805	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	306,876	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/30/2023 10:22 am

Title XVIII | Hospital | PPS

	Cost Center Description						
						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	91,442	4,215,212	0.021693	0	0	90.00
91.00	Nursing Program cost	0	4,215,212	0.000000	0	0	91.00
92.00	Allied health cost	0	4,215,212	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,215,212	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/30/2023 10:22 am

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)	2,056	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,056	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,056	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)	140	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)	4,215,212	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)	4,215,212	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)	4,215,212	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,050.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	287,028	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)	287,028	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/30/2023 10:22 am

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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	287,028	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
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-4021	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/30/2023 10:22 am
	Title XIX	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	91,442	4,215,212	0.021693	0	0	90.00
91.00	Nursing Program cost	0	4,215,212	0.000000	0	0	91.00
92.00	Allied health cost	0	4,215,212	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,215,212	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/30/2023 10:22 am

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		167,229		30.00
		ANCILLARY SERVICE COST CENTERS				
60.00	06000	LABORATORY	0.837553	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.837560	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	4.030225	0	0	90.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/30/2023 10:22 am

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		153,020		30.00
	ANCILLARY SERVICE COST CENTERS					
60.00	06000	LABORATORY	0.837553	0	0	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.837560	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	4.030225	0	0	90.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E Part B Date/Time Prepared: 11/30/2023 10:22 am

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	282,922	2.00
3.00	OPPS or REH payments	82,063	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	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)	82,063	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)	17,322	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)	64,741	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	64,741	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	64,741	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)	7,159	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	4,653	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	69,394	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)	69,394	40.00
40.01	Sequestration adjustment (see instructions)	1,388	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	63,446	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)	4,560	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
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-4021	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/30/2023 10:22 am
	Title XVIII	Hospital	PPS

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I Date/Time Prepared: 11/30/2023 10:22 am

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		114,665		63,446	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)		114,665		63,446	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		7,531		4,560	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		122,196		68,006	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-4021	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part II Date/Time Prepared: 11/30/2023 10:22 am
	Title XVIII	Hospital	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)	152,770	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	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)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	5.632877	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	152,770	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)	152,770	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	152,770	18.00
19.00	Deductibles	35,765	19.00
20.00	Subtotal (line 18 minus line 19)	117,005	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	117,005	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	11,823	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	7,685	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	124,690	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	Other pass through costs (see instructions)	0	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)	124,690	31.00
31.01	Sequestration adjustment (see instructions)	2,494	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	114,665	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)	7,531	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)	0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-3 Part VII | Date/Time Prepared: 11/30/2023 10:22 am

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	287,028		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)	287,028	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)	287,028	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	153,020		8.00
9.00	Ancillary service charges	0	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)	153,020	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)	153,020	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	134,008	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)	153,020	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)	153,020	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	134,008	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	153,020	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)	153,020	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	153,020	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)	153,020	0	40.00
41.00	Interim payments	200,385	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-47,365	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G | Date/Time Prepared: 11/30/2023 10:22 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3,565,780	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,025,379	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-893,865	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	232,081	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)	5,929,375	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	438,237	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	8,116,651	0	0	0	15.00
16.00	Accumulated depreciation	-5,773,026	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	2,688,580	0	0	0	19.00
20.00	Accumulated depreciation	-1,871,789	0	0	0	20.00
21.00	Automobiles and trucks	121,719	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	768,242	0	0	0	23.00
24.00	Accumulated depreciation	-509,227	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)	3,979,387	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	9,908,762	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	666,461	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,137,795	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,804,256	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,500,397	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,500,397	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,304,653	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	6,604,109				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)	6,604,109	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	9,908,762	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-1 | Date/Time Prepared: 11/30/2023 10:22 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		7,269,159		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-665,050				2.00
3.00	Total (sum of line 1 and line 2)		6,604,109		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		6,604,109		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		6,604,109		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	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: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/30/2023 10:22 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,652,696		4,652,696	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,652,696		4,652,696	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,652,696		4,652,696	17.00
18.00	Ancillary services	226,827	0	226,827	18.00
19.00	Outpatient services	2,776,043	914,790	3,690,833	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NONREIMBURSABLE	0	3,317,517	3,317,517	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,655,566	4,232,307	11,887,873	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		27,699,594		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)		27,699,594		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-4021 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-3 | Date/Time Prepared: 11/30/2023 10:22 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	11,887,873	1.00
2.00	Less contractual allowances and discounts on patients' accounts	662,922	2.00
3.00	Net patient revenues (line 1 minus line 2)	11,224,951	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	27,699,594	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-16,474,643	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	9,173,937	24.00
24.01	LTC REVENUE	0	24.01
24.02	GAIN/LOSS DISP ASSET-MISC	0	24.02
24.03	GRANT REVENUE	5,309,812	24.03
24.04	DONATIONS FROM FOUNDATION	0	24.04
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	14,483,749	25.00
26.00	Total (line 5 plus line 25)	-1,990,894	26.00
27.00	OTHER RECONCILING ITEMS	-1,325,844	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-1,325,844	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-665,050	29.00