

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: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 4/30/2024 11:02 am
--	-----------------------	---------------------------------------	--

**PART I - COST REPORT STATUS**

Provider use only 1.  Electronically prepared cost report Date: 4/30/2024 Time: 11:02 am  
 2.  Manually prepared cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

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

**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 Lafayette Regional Rehabilitation Hospital ( 15-3042 ) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2			
1	<b>Caleb Reed</b>		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	Caleb Reed			2
3	Signatory Title	EVP FINANCE			3
4	Date	(Dated when report is electronic)			4

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
		1.00	2.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00	HOSPITAL	0	156,323	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	2.00
3.00	SUBPROVIDER - IRF	0	0	0	0	3.00
5.00	SWING BED - SNF	0	0	0	0	5.00
6.00	SWING BED - NF	0	0	0	0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0	0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	9.00
200.00	TOTAL	0	156,323	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 4/30/2024 11:02 am
---	--	-----------------------	---	--

1.00	2.00	3.00	4.00
Hospital and Hospital Health Care Complex Address:			
1.00	Street: 950 Park East Blvd	PO Box:	1.00
2.00	City: Lafayette	State: IN	2.00
		Zip Code: 47905	
		County: TIPPECANOE	

	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	Lafayette Regional Rehabilitation Hospital	153042	29200	5	04/18/2013	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:		
						1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2023	12/31/2023	20.00	
21.00	Type of Control (see instructions)					4		21.00	
						1.00	2.00	3.00	

Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				N	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: 15-3042			Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 4/30/2024 11:02 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.	42	118	0	0	1,346			25.00			
						Urban/Rural S		Date of Geogr				
						1.00		2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00				
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00				
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00				
						Beginning:		Ending:				
						1.00		2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00				
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00				
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01				
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00				
						Y/N		Y/N				
						1.00		2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N		N		39.00		
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N		N		40.00		
						V		XVII		XIX		
						1.00		2.00		3.00		
<b>Prospective Payment System (PPS)-Capital</b>												
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
<b>Teaching Hospitals</b>												
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N						56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.											57.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 4/30/2024 11:02 am
---	--	-----------------------	---	--

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

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	

61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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: 15-3042		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 4/30/2024 11:02 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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 4/30/2024 11:02 am		
					1.00	
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?				68.00	
					1.00 2.00 3.00	
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N N 0	76.00
					1.00	
<b>Long Term Care Hospital PPS</b>						
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
<b>TEFRA Providers</b>						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.				N	87.00
					1.00 2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.				N 0	88.00
					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	
<b>Title V and XIX Services</b>						
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	N 90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.				N	N 91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	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: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 4/30/2024 11:02 am	
		V 1.00	XIX 2.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? 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	
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				109.00
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00
				1.00	2.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.		N		111.00
				1.00	2.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
<b>Miscellaneous Cost Reporting Information</b>					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		0		118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 4/30/2024 11:02 am
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	0	0	0
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N	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	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.		N	123.00
<b>Certified Transplant Center Information</b>				
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
<b>All Providers</b>				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	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: ERNEST HEALTH INC	Contractor's Name: NOVITAS SOLUTIONS		Contractor's Number: 04011
142.00	Street: 1024 N GALLOWAY AVE	PO Box:		
143.00	City: MESQUITE	State: TX	Zip Code: 75149	
			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.		Y	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N	146.00



HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-3042		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 4/30/2024 11:02 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	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	N	157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00	
161.00	CMHC		N	N	N	N	161.00	
1.00								
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
1.00								
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
Beginni ng      Endi ng								
1.00      2.00								
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00
1.00      2.00								
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-3042		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part II Date/Time Prepared: 4/30/2024 11:02 am	
				Y/N	Date		
				1.00	2.00		
<b>PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE</b>							
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
<b>Financial Data and Reports</b>							
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		
<b>Approved Educational Activities</b>							
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			
<b>Bad Debts</b>							
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
<b>Bed Complement</b>							
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
<b>PS&amp;R Data</b>							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/16/2024	N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 4/30/2024 11:02 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	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
<b>Interest Expense</b>					
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
<b>Purchased Services</b>					
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
<b>Provider-Based Physicians</b>					
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	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00		2.00	
<b>Cost Report Preparer Contact Information</b>					
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.	Mary		Pitcock	41.00
42.00	Enter the employer/company name of the cost report preparer.	Ernest Health Inc			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	903-588-0077		marykay@ernesthealth.com	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-3042

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
4/30/2024 11:02 am

		3.00	
<b>Cost Report Preparer Contact Information</b>			
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.	Reimbursement 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: 15-3042

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/30/2024 11:02 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P	Title V
	Line No.				Visits / Trips	
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - STATISTICAL DATA</b>						
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	40	14,600	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)		40	14,600	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)		40	14,600	0.00	0	14.00
15.00 CAH visits					0	15.00
15.10 REH hours and visits				0.00	0	15.10
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						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)		40				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: 15-3042

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/30/2024 11:02 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
<b>PART I - STATISTICAL DATA</b>						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,701	42	9,432		1.00
2.00	HMO and other (see instructions)	622	1,464			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0	0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,701	42	9,432		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)	4,701	42	9,432	0.00	100.46
15.00	CAH visits	0	0	0		15.00
15.10	REH hours and visits	0	0	0		15.10
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	100.46
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: 15-3042

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/30/2024 11:02 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
<b>PART I - STATISTICAL DATA</b>							
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	337	2	632	1.00
2.00	HMO and other (see instructions)			33	96		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	337	2	632	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	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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: 15-3042

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

Worksheet A  
Date/Time Prepared:  
4/30/2024 11:02 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		1,923,579	1,923,579	209,931	2,133,510	1.00
2.00	00200		192,943	192,943	53,988	246,931	2.00
3.00	00300		263,919	263,919	-263,919	0	3.00
4.00	00400	571,919	958,896	1,530,815	0	1,530,815	4.00
5.00	00500	1,747,652	1,424,219	3,171,871	0	3,171,871	5.00
7.00	00700	62,119	435,776	497,895	0	497,895	7.00
8.00	00800	0	50,515	50,515	0	50,515	8.00
9.00	00900	169,873	95,328	265,201	0	265,201	9.00
10.00	01000	326,442	242,324	568,766	0	568,766	10.00
13.00	01300	408,476	32,251	440,727	0	440,727	13.00
16.00	01600	54,895	7,082	61,977	0	61,977	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,649,220	760,514	3,409,734	0	3,409,734	30.00
44.00	04400	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	0	45,126	45,126	0	45,126	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	79,880	79,880	0	79,880	60.00
65.00	06500	102,785	29,551	132,336	0	132,336	65.00
66.00	06600	608,183	107,732	715,915	51,739	767,654	66.00
67.00	06700	411,927	168,281	580,208	139,182	719,390	67.00
68.00	06800	215,029	19,206	234,235	53,379	287,614	68.00
71.00	07100	44,490	128,150	172,640	0	172,640	71.00
73.00	07300	91,610	284,950	376,560	0	376,560	73.00
74.00	07400	0	179,014	179,014	0	179,014	74.00
76.00	03950	0	-85,323	-85,323	0	-85,323	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	0	0	0	0	0	91.00
91.01	04951	225,637	18,663	244,300	-244,300	0	91.01
93.00	04950	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
117.00	06950	0	0	0	0	0	117.00
118.00		7,690,257	7,362,576	15,052,833	0	15,052,833	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00		7,690,257	7,362,576	15,052,833	0	15,052,833	200.00



RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-3042

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

Worksheet A  
Date/Time Prepared:  
4/30/2024 11:02 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	27,630	2,161,140	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	13,405	260,336	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,456	1,528,359	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	705,586	3,877,457	5.00
7.00	00700	OPERATION OF PLANT	-11,286	486,609	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	50,515	8.00
9.00	00900	HOUSEKEEPING	0	265,201	9.00
10.00	01000	DIETARY	-6,929	561,837	10.00
13.00	01300	NURSING ADMINISTRATION	0	440,727	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-120	61,857	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-168	3,409,566	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	45,126	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	79,880	60.00
65.00	06500	RESPIRATORY THERAPY	0	132,336	65.00
66.00	06600	PHYSICAL THERAPY	0	767,654	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	719,390	67.00
68.00	06800	SPEECH PATHOLOGY	0	287,614	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-6	172,634	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	376,560	73.00
74.00	07400	RENAL DIALYSIS	0	179,014	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	103,800	18,477	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100	EMERGENCY	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	829,456	15,882,289	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	MARKETING	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	829,456	15,882,289	200.00

RECLASSIFICATIONS

Provider CCN: 15-3042

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

Worksheet A-6

Date/Time Prepared:  
4/30/2024 11:02 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
<b>A - RCLS PCT THERAPY</b>					
1.00	OCCUPATIONAL THERAPY	67.00	42,304	3,793	1.00
2.00	SPEECH PATHOLOGY	68.00	16,224	1,455	2.00
	TOTALS		58,528	5,248	
<b>B - RCLS O/P THERAPY</b>					
1.00	PHYSICAL THERAPY	66.00	106,690	8,825	1.00
2.00	OCCUPATIONAL THERAPY	67.00	85,974	7,111	2.00
3.00	SPEECH PATHOLOGY	68.00	32,973	2,727	3.00
	TOTALS		225,637	18,663	
500.00	Grand Total: Increases		284,165	23,911	500.00

RECLASSIFICATIONS

Provider CCN: 15-3042

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

Worksheet A-6

Date/Time Prepared:  
4/30/2024 11:02 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
<b>A - RCLS PCT THERAPY</b>						
1.00	PHYSICAL THERAPY	66.00	58,528	5,248	0	1.00
2.00		0.00	0	0	0	2.00
	<b>TOTALS</b>		58,528	5,248		
<b>B - RCLS O/P THERAPY</b>						
1.00	OUTPATIENT THERAPY	91.01	225,637	18,663	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	<b>TOTALS</b>		225,637	18,663		
500.00	<b>Grand Total: Decreases</b>		284,165	23,911		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-3042

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
4/30/2024 11:02 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	10,661,867	41,400	0	41,400	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	22,926	1,186	0	1,186	0	5.00
6.00	Movable Equipment	3,076,662	-317,910	0	-317,910	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	13,761,455	-275,324	0	-275,324	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	13,761,455	-275,324	0	-275,324	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	10,703,267	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	24,112	0				5.00
6.00	Movable Equipment	2,758,752	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	13,486,131	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	13,486,131	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-3042

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
4/30/2024 11:02 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	166,293	1,718,720	38,566	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	131,892	61,051	0	0	0	2.00
3.00	Total (sum of lines 1-2)	298,185	1,779,771	38,566	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,923,579				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	192,943				2.00
3.00	Total (sum of lines 1-2)	0	2,116,522				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-3042

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
4/30/2024 11:02 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	10,727,379	0	10,727,379	0.795438	25,376	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,758,752	0	2,758,752	0.204562	6,526	2.00
3.00	Total (sum of lines 1-2)	13,486,131	0	13,486,131	1.000000	31,902	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	184,555	0	209,931	193,923	1,718,720	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	47,462	0	53,988	145,297	61,051	2.00
3.00	Total (sum of lines 1-2)	232,017	0	263,919	339,220	1,779,771	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	38,566	25,376	184,555	0	2,161,140	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,526	47,462	0	260,336	2.00
3.00	Total (sum of lines 1-2)	38,566	31,902	232,017	0	2,421,476	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-3042

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

Worksheet A-8

Date/Time Prepared:  
4/30/2024 11:02 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-1,764		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-9,550		OPERATION OF PLANT	7.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2		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	1,189,488				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-6,690		DIETARY	10.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-120		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 INTEREST INCOME	B	1,767		ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-3042

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

Worksheet A-8

Date/Time Prepared:  
4/30/2024 11:02 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.02 MIS INCOME	B	-16,535	ADMINISTRATIVE & GENERAL		5.00	0 33.02
33.07 OTHER EXPENSE-ADVERTISING/MARKETING-OTHER	A	409	ADMINISTRATIVE & GENERAL		5.00	0 33.07
33.08 OTHER EXPENSE-ADVERTISING/MARKETING-OTHER	A	-32,785	ADMINISTRATIVE & GENERAL		5.00	0 33.08
33.09 OTHER EXPENSE-ADVERTISING/MARKETING-OTHER	A	-2,930	ADMINISTRATIVE & GENERAL		5.00	0 33.09
33.14 BAD DEBT EXPENSE-BAD DEBT--	A	-308,392	ADMINISTRATIVE & GENERAL		5.00	0 33.14
33.22 OTHER EXPENSE-CONTRIBUTIONS / SPONSO	A	-1,200	ADMINISTRATIVE & GENERAL		5.00	0 33.22
33.34 OTHER EXPENSE-CONTRIBUTIONS / SPONSO	A	-5,092	ADMINISTRATIVE & GENERAL		5.00	0 33.34
33.35 OTHER EXPENSE-FLOWERS & GIFTS--	A	-104	ADMINISTRATIVE & GENERAL		5.00	0 33.35
33.56 TAXES-FRANCHISE FEES/BUSINESS TAX--	A	-372	ADMINISTRATIVE & GENERAL		5.00	0 33.56
33.69 OTHER EXPENSE-GIVEAWAYS--	A	-168	ADULTS & PEDIATRICS		30.00	0 33.69
33.74 OTHER EXPENSE-GIVEAWAYS--	A	-1,854	ADMINISTRATIVE & GENERAL		5.00	0 33.74
33.93 OTHER EXPENSE-GIVEAWAYS--	A	-561	ADMINISTRATIVE & GENERAL		5.00	0 33.93
33.95 OTHER FEES-LATE FEES--	A	-6	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	0 33.95
34.10 OTHER FEES-LATE FEES--	A	-1,736	OPERATION OF PLANT		7.00	0 34.10
34.13 OTHER FEES-LATE FEES--	A	-239	DIETARY		10.00	0 34.13
34.14 OTHER FEES-LATE FEES--	A	-150	ADMINISTRATIVE & GENERAL		5.00	0 34.14
34.18 OTHER FEES-LATE FEES--	A	-75	ADMINISTRATIVE & GENERAL		5.00	0 34.18
34.21 TAXES-SALES TAX--	A	-919	ADMINISTRATIVE & GENERAL		5.00	0 34.21
34.46 TAXES-USE TAX--	A	-2,666	ADMINISTRATIVE & GENERAL		5.00	0 34.46
34.47 NON-OPERATING REALIZED GAIN/LOSS-NON	A	18,982	ADMINISTRATIVE & GENERAL		5.00	0 34.47
34.51 MARKETING EXPENSE	A	-7,774	ADMINISTRATIVE & GENERAL		5.00	0 34.51
34.52 MARKETING BENEFITS	A	-868	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 34.52
34.53 TELEPHONE OPERATOR EXPENSE	A	-12,805	ADMINISTRATIVE & GENERAL		5.00	0 34.53
34.54 TELEPHONE BENEFIT EXPENSE	A	-1,588	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 34.54
34.55 TELEVISION DEPRECIATION	A	-537	CAP REL COSTS-MVBLE EQUIP		2.00	9 34.55
34.56 UNALLOWABLE LOBBYING % OF ASSOC DUES	A	-4,277	ADMINISTRATIVE & GENERAL		5.00	0 34.56
34.57 MED DIR 2022 OVER ACCRUAL AND ACCRUA	A	43,455	ADMINISTRATIVE & GENERAL		5.00	0 34.57
34.58 CONTRACT SERVICES-PHYSICIAN GUARANTEE	A	-106,688	ADMINISTRATIVE & GENERAL		5.00	0 34.58
34.59 OUTSIDE LOA PRIOR PD INVOICES & PRIO	A	103,800	OTHER ANCILLARY SERVICE COST CENTERS		76.00	0 34.59
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		829,456				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.



STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS  
 Provider CCN: 15-3042  
 Period: From 01/01/2023 To 12/31/2023  
 Worksheet A-8-1  
 Date/Time Prepared: 4/30/2024 11:02 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HO Alloc - Cap Rel Bldg	27,630	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO Alloc - Cap Rel Equipment	13,942	0
3.00	5.00	ADMINISTRATIVE & GENERAL	HO Alloc - Cap Rel A&G	1,467,810	0
4.00	5.00	ADMINISTRATIVE & GENERAL	Intercompany Management Fees	0	319,894
5.00	0			1,509,382	319,894

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

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

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

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

6.00	B		0.00	ERNEST HEALTH	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	FINANCIAL				100.00

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

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

Provider CCN: 15-3042

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

Worksheet A-8-1

Date/Time Prepared:  
4/30/2024 11:02 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	27,630	9		1.00
2.00	13,942	9		2.00
3.00	1,467,810	0		3.00
4.00	-319,894	0		4.00
5.00	1,189,488			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3042

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

Worksheet B  
Part I  
Date/Time Prepared:  
4/30/2024 11:02 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,161,140	2,161,140			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	260,336		260,336		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,528,359	8,694	1,047	1,538,100	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,877,457	144,405	17,395	377,626	5.00
7.00 00700	OPERATION OF PLANT	486,609	497,018	59,872	13,422	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	50,515	0	0	0	8.00
9.00 00900	HOUSEKEEPING	265,201	14,083	1,696	36,705	9.00
10.00 01000	DIETARY	561,837	198,336	23,892	70,536	10.00
13.00 01300	NURSING ADMINISTRATION	440,727	22,686	2,733	88,262	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	61,857	23,547	2,836	11,861	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	3,409,566	881,917	106,239	572,433	30.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY-DIAGNOSTIC	45,126	0	0	0	54.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00 06000	LABORATORY	79,880	0	0	0	60.00
65.00 06500	RESPIRATORY THERAPY	132,336	9,056	1,091	22,209	65.00
66.00 06600	PHYSICAL THERAPY	767,654	154,412	18,601	141,820	66.00
67.00 06700	OCCUPATIONAL THERAPY	719,390	86,082	10,370	116,725	67.00
68.00 06800	SPEECH PATHOLOGY	287,614	9,962	1,200	57,093	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	172,634	20,830	2,509	9,613	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	376,560	25,358	3,055	19,795	73.00
74.00 07400	RENAL DIALYSIS	179,014	0	0	0	74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	18,477	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	0	0	0	0	91.00
91.01 04951	OUTPATIENT THERAPY	0	0	0	0	91.01
93.00 04950	OUTPATIENT WOUND CENTER	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
117.00 06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	15,882,289	2,096,386	252,536	1,538,100	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	64,663	7,789	0	192.00
194.00 07950	MARKETING	0	91	11	0	194.00
194.01 07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	15,882,289	2,161,140	260,336	1,538,100	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3042

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

Worksheet B  
Part I  
Date/Time Prepared:  
4/30/2024 11:02 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,416,883				5.00
7.00	00700	OPERATION OF PLANT	407,164	1,464,085			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	19,460		69,975		8.00
9.00	00900	HOUSEKEEPING	122,384	13,645	0	453,714	9.00
10.00	01000	DIETARY	329,223	192,175	0	60,115	1,436,114
13.00	01300	NURSING ADMINISTRATION	213,578	21,982	0	6,876	0
16.00	01600	MEDICAL RECORDS & LIBRARY	38,563	22,815	0	7,137	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,914,678	854,521	69,975	267,304	1,436,114
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,384	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00	06000	LABORATORY	30,773	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	63,445	8,775	0	2,745	0
66.00	06600	PHYSICAL THERAPY	417,013	149,616	0	46,802	0
67.00	06700	OCCUPATIONAL THERAPY	359,258	83,408	0	26,091	0
68.00	06800	SPEECH PATHOLOGY	137,094	9,653	0	3,019	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	79,199	20,183	0	6,313	0
73.00	07300	DRUGS CHARGED TO PATIENTS	163,636	24,570	0	7,686	0
74.00	07400	RENAL DIALYSIS	68,963	0	0	0	0
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	7,118	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	0	0	0	0	0
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,388,933	1,401,343	69,975	434,088	1,436,114
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	27,911	62,654	0	19,599	0
194.00	07950	MARKETING	39	88	0	27	0
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	4,416,883	1,464,085	69,975	453,714	1,436,114

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3042

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

Worksheet B  
Part I  
Date/Time Prepared:  
4/30/2024 11:02 am

Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		13.00	16.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
13.00	01300	796,844					13.00
16.00	01600	0	168,616				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	796,844	73,226	10,382,817	0	10,382,817	30.00
44.00	04400	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	0	1,489	63,999	0	63,999	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	9,963	120,616	0	120,616	60.00
65.00	06500	0	5,787	245,444	0	245,444	65.00
66.00	06600	0	24,291	1,720,209	0	1,720,209	66.00
67.00	06700	0	19,574	1,420,898	0	1,420,898	67.00
68.00	06800	0	7,507	513,142	0	513,142	68.00
71.00	07100	0	2,288	313,569	0	313,569	71.00
73.00	07300	0	21,505	642,165	0	642,165	73.00
74.00	07400	0	2,986	250,963	0	250,963	74.00
76.00	03950	0	0	25,595	0	25,595	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	0	0	0	0	0	91.00
91.01	04951	0	0	0	0	0	91.01
93.00	04950	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
117.00	06950	0	0	0	0	0	117.00
118.00		796,844	168,616	15,699,417	0	15,699,417	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	0	0	182,616	0	182,616	192.00
194.00	07950	0	0	256	0	256	194.00
194.01	07951	0	0	0	0	0	194.01
200.00				0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		796,844	168,616	15,882,289	0	15,882,289	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3042

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

Worksheet B  
Part II  
Date/Time Prepared:  
4/30/2024 11:02 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,694	1,047	9,741	9,741 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	144,405	17,395	161,800	2,391 5.00
7.00 00700	OPERATION OF PLANT	0	497,018	59,872	556,890	85 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0 8.00
9.00 00900	HOUSEKEEPING	0	14,083	1,696	15,779	232 9.00
10.00 01000	DIETARY	0	198,336	23,892	222,228	447 10.00
13.00 01300	NURSING ADMINISTRATION	0	22,686	2,733	25,419	559 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	23,547	2,836	26,383	75 16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	881,917	106,239	988,156	3,627 30.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
60.00 06000	LABORATORY	0	0	0	0	0 60.00
65.00 06500	RESPIRATORY THERAPY	0	9,056	1,091	10,147	141 65.00
66.00 06600	PHYSICAL THERAPY	0	154,412	18,601	173,013	898 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	86,082	10,370	96,452	739 67.00
68.00 06800	SPEECH PATHOLOGY	0	9,962	1,200	11,162	361 68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,830	2,509	23,339	61 71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	25,358	3,055	28,413	125 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	0	0	0	0	0 91.00
91.01 04951	OUTPATIENT THERAPY	0	0	0	0	0 91.01
93.00 04950	OUTPATIENT WOUND CENTER	0	0	0	0	0 93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
117.00 06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0 117.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	2,096,386	252,536	2,348,922	9,741 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	64,663	7,789	72,452	0 192.00
194.00 07950	MARKETING	0	91	11	102	0 194.00
194.01 07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.01
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	2,161,140	260,336	2,421,476	9,741 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 4/30/2024 11:02 am
-------------------------------------	--	-----------------------	---	---

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	164,191				5.00
7.00	00700	OPERATION OF PLANT	15,136	572,111			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	723	0	723		8.00
9.00	00900	HOUSEKEEPING	4,550	5,332	0	25,893	9.00
10.00	01000	DIETARY	12,239	75,095	0	3,431	313,440
13.00	01300	NURSING ADMINISTRATION	7,940	8,590	0	392	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,434	8,915	0	407	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	71,172	333,916	723	15,255	313,440
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	646	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00	06000	LABORATORY	1,144	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	2,359	3,429	0	157	0
66.00	06600	PHYSICAL THERAPY	15,502	58,464	0	2,671	0
67.00	06700	OCCUPATIONAL THERAPY	13,355	32,593	0	1,489	0
68.00	06800	SPEECH PATHOLOGY	5,096	3,772	0	172	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,944	7,887	0	360	0
73.00	07300	DRUGS CHARGED TO PATIENTS	6,083	9,601	0	439	0
74.00	07400	RENAL DIALYSIS	2,564	0	0	0	0
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	265	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	0	0	0	0	0
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	163,152	547,594	723	24,773	313,440
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,038	24,483	0	1,118	0
194.00	07950	MARKETING	1	34	0	2	0
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	164,191	572,111	723	25,893	313,440

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3042

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

Worksheet B  
Part II  
Date/Time Prepared:  
4/30/2024 11:02 am

Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		13.00	16.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
13.00	01300	42,900					13.00
16.00	01600	0	37,214				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	42,900	16,165	1,785,354	0	1,785,354	30.00
44.00	04400	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	0	328	974	0	974	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	2,199	3,343	0	3,343	60.00
65.00	06500	0	1,277	17,510	0	17,510	65.00
66.00	06600	0	5,360	255,908	0	255,908	66.00
67.00	06700	0	4,319	148,947	0	148,947	67.00
68.00	06800	0	1,657	22,220	0	22,220	68.00
71.00	07100	0	505	35,096	0	35,096	71.00
73.00	07300	0	4,745	49,406	0	49,406	73.00
74.00	07400	0	659	3,223	0	3,223	74.00
76.00	03950	0	0	265	0	265	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	0	0	0	0	0	91.00
91.01	04951	0	0	0	0	0	91.01
93.00	04950	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
117.00	06950	0	0	0	0	0	117.00
118.00		42,900	37,214	2,322,246	0	2,322,246	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	0	0	99,091	0	99,091	192.00
194.00	07950	0	0	139	0	139	194.00
194.01	07951	0	0	0	0	0	194.01
200.00				0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		42,900	37,214	2,421,476	0	2,421,476	202.00



COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-3042

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

Worksheet B-1  
Date/Time Prepared:  
4/30/2024 11:02 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	47,726				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		47,726			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	192	192	7,118,338		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,189	3,189	1,747,652	-4,416,883	11,465,406
7.00 00700	OPERATION OF PLANT	10,976	10,976	62,119	0	1,056,921
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	50,515
9.00 00900	HOUSEKEEPING	311	311	169,873	0	317,685
10.00 01000	DIETARY	4,380	4,380	326,442	0	854,601
13.00 01300	NURSING ADMINISTRATION	501	501	408,476	0	554,408
16.00 01600	MEDICAL RECORDS & LIBRARY	520	520	54,895	0	100,101
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	19,476	19,476	2,649,220	0	4,970,155
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	45,126
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00 06000	LABORATORY	0	0	0	0	79,880
65.00 06500	RESPIRATORY THERAPY	200	200	102,785	0	164,692
66.00 06600	PHYSICAL THERAPY	3,410	3,410	656,344	0	1,082,487
67.00 06700	OCCUPATIONAL THERAPY	1,901	1,901	540,205	0	932,567
68.00 06800	SPEECH PATHOLOGY	220	220	264,227	0	355,869
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	460	460	44,490	0	205,586
73.00 07300	DRUGS CHARGED TO PATIENTS	560	560	91,610	0	424,768
74.00 07400	RENAL DIALYSIS	0	0	0	0	179,014
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	18,477
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	0	0	0	0	0
91.01 04951	OUTPATIENT THERAPY	0	0	0	0	0
93.00 04950	OUTPATIENT WOUND CENTER	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
117.00 06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	46,296	46,296	7,118,338	-4,416,883	11,392,852
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,428	1,428	0	0	72,452
194.00 07950	MARKETING	2	2	0	0	102
194.01 07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,161,140	260,336	1,538,100		4,416,883
203.00	Unit cost multiplier (Wkst. B, Part I)	45.282236	5.454805	0.216076		0.385236
204.00	Cost to be allocated (per Wkst. B, Part II)			9,741		164,191
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001368		0.014321
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: 15-3042

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

Worksheet B-1

Date/Time Prepared:  
4/30/2024 11:02 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	NURSING ADMINISTRATION (NURSING SALARIES)	
		7.00	8.00	9.00	10.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700	33,369					7.00
8.00	00800	0	9,432				8.00
9.00	00900	311	0	33,058			9.00
10.00	01000	4,380	0	4,380	9,432		10.00
13.00	01300	501	0	501	0	2,649,220	13.00
16.00	01600	520	0	520	0	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	19,476	9,432	19,476	9,432	2,649,220	30.00
44.00	04400	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	0	0	0	0	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	0	0	0	0	60.00
65.00	06500	200	0	200	0	0	65.00
66.00	06600	3,410	0	3,410	0	0	66.00
67.00	06700	1,901	0	1,901	0	0	67.00
68.00	06800	220	0	220	0	0	68.00
71.00	07100	460	0	460	0	0	71.00
73.00	07300	560	0	560	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03950	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	0	0	0	0	0	91.00
91.01	04951	0	0	0	0	0	91.01
93.00	04950	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
117.00	06950	0	0	0	0	0	117.00
118.00		31,939	9,432	31,628	9,432	2,649,220	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	1,428	0	1,428	0	0	192.00
194.00	07950	2	0	2	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		1,464,085	69,975	453,714	1,436,114	796,844	202.00
203.00		43.875603	7.418893	13.724787	152.259754	0.300784	203.00
204.00		572,111	723	25,893	313,440	42,900	204.00
205.00		17.144985	0.076654	0.783260	33.231552	0.016193	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-3042

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

Worksheet B-1

Date/Time Prepared:  
4/30/2024 11:02 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		16.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
		22,741,605	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
44.00	04400	SKILLED NURSING FACILITY	44.00
		9,875,250	
		0	
<b>ANCILLARY SERVICE COST CENTERS</b>			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	76.00
		200,781	
		0	
		0	
		1,343,835	
		780,548	
		3,276,375	
		2,640,205	
		1,012,590	
		308,627	
		2,900,644	
		402,750	
		0	
<b>OUTPATIENT SERVICE COST CENTERS</b>			
91.00	09100	EMERGENCY	91.00
91.01	04951	OUTPATIENT THERAPY	91.01
93.00	04950	OUTPATIENT WOUND CENTER	93.00
		0	
		0	
		0	
<b>OTHER REIMBURSABLE COST CENTERS</b>			
95.00	09500	AMBULANCE SERVICES	95.00
101.00	10100	HOME HEALTH AGENCY	101.00
		0	
		0	
<b>SPECIAL PURPOSE COST CENTERS</b>			
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		22,741,605	
<b>NONREIMBURSABLE COST CENTERS</b>			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	MARKETING	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	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)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	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
		168,616	
		0.007414	
		37,214	
		0.001636	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-3042

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

Worksheet C  
Part I  
Date/Time Prepared:  
4/30/2024 11:02 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	10,382,817		10,382,817	0	10,382,817 30.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0 44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00	05400 RADIOLOGY-DIAGNOSTIC	63,999		63,999	0	63,999 54.00
57.00	05700 CT SCAN	0		0	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0 58.00
60.00	06000 LABORATORY	120,616		120,616	0	120,616 60.00
65.00	06500 RESPIRATORY THERAPY	245,444	0	245,444	0	245,444 65.00
66.00	06600 PHYSICAL THERAPY	1,720,209	0	1,720,209	0	1,720,209 66.00
67.00	06700 OCCUPATIONAL THERAPY	1,420,898	0	1,420,898	0	1,420,898 67.00
68.00	06800 SPEECH PATHOLOGY	513,142	0	513,142	0	513,142 68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	313,569		313,569	0	313,569 71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	642,165		642,165	0	642,165 73.00
74.00	07400 RENAL DIALYSIS	250,963		250,963	0	250,963 74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	25,595		25,595	0	25,595 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100 EMERGENCY	0		0	0	0 91.00
91.01	04951 OUTPATIENT THERAPY	0		0	0	0 91.01
93.00	04950 OUTPATIENT WOUND CENTER	0		0	0	0 93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	0		0	0	0 95.00
101.00	10100 HOME HEALTH AGENCY	0		0	0	0 101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
117.00	06950 OTHER SPECIAL PURPOSE COST CENTERS	0		0		0 117.00
200.00	Subtotal (see instructions)	15,699,417	0	15,699,417	0	15,699,417 200.00
201.00	Less Observation Beds	0		0		0 201.00
202.00	Total (see instructions)	15,699,417	0	15,699,417	0	15,699,417 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 4/30/2024 11:02 am
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	9,875,250		9,875,250			30.00
44.00 04400 SKILLED NURSING FACILITY	0		0			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400 RADIOLOGY-DIAGNOSTIC	200,781	0	200,781	0.318750	0.000000	54.00
57.00 05700 CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00 06000 LABORATORY	1,343,835	0	1,343,835	0.089755	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	780,548	0	780,548	0.314451	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	2,368,715	907,660	3,276,375	0.525034	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	2,278,440	361,765	2,640,205	0.538177	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	821,210	191,380	1,012,590	0.506762	0.000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	308,627	0	308,627	1.016013	0.000000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2,900,644	0	2,900,644	0.221387	0.000000	73.00
74.00 07400 RENAL DIALYSIS	402,750	0	402,750	0.623124	0.000000	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100 EMERGENCY	0	0	0	0.000000	0.000000	91.00
91.01 04951 OUTPATIENT THERAPY	0	0	0	0.000000	0.000000	91.01
93.00 04950 OUTPATIENT WOUND CENTER	0	0	0	0.000000	0.000000	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00 10100 HOME HEALTH AGENCY	0	0	0			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
117.00 06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0			117.00
200.00 Subtotal (see instructions)	21,280,800	1,460,805	22,741,605			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	21,280,800	1,460,805	22,741,605			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 4/30/2024 11:02 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
44.00	04400 SKILLED NURSING FACILITY			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.318750		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000 LABORATORY	0.089755		60.00
65.00	06500 RESPIRATORY THERAPY	0.314451		65.00
66.00	06600 PHYSICAL THERAPY	0.525034		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.538177		67.00
68.00	06800 SPEECH PATHOLOGY	0.506762		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.016013		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.221387		73.00
74.00	07400 RENAL DIALYSIS	0.623124		74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	09100 EMERGENCY	0.000000		91.00
91.01	04951 OUTPATIENT THERAPY	0.000000		91.01
93.00	04950 OUTPATIENT WOUND CENTER	0.000000		93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
101.00	10100 HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
117.00	06950 OTHER SPECIAL PURPOSE COST CENTERS			117.00
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: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 4/30/2024 11:02 am
		Title XIX	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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000 ADULTS & PEDIATRICS		10,382,817		10,382,817	0	10,382,817	30.00
44.00	04400 SKILLED NURSING FACILITY		0		0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400 RADIOLOGY-DIAGNOSTIC		63,999		63,999	0	63,999	54.00
57.00	05700 CT SCAN		0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0		0	0	0	58.00
60.00	06000 LABORATORY		120,616		120,616	0	120,616	60.00
65.00	06500 RESPIRATORY THERAPY	0	245,444		245,444	0	245,444	65.00
66.00	06600 PHYSICAL THERAPY	0	1,720,209		1,720,209	0	1,720,209	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,420,898		1,420,898	0	1,420,898	67.00
68.00	06800 SPEECH PATHOLOGY	0	513,142		513,142	0	513,142	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		313,569		313,569	0	313,569	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS		642,165		642,165	0	642,165	73.00
74.00	07400 RENAL DIALYSIS		250,963		250,963	0	250,963	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS		25,595		25,595	0	25,595	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100 EMERGENCY		0		0	0	0	91.00
91.01	04951 OUTPATIENT THERAPY		0		0	0	0	91.01
93.00	04950 OUTPATIENT WOUND CENTER		0		0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500 AMBULANCE SERVICES		0		0	0	0	95.00
101.00	10100 HOME HEALTH AGENCY		0		0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
117.00	06950 OTHER SPECIAL PURPOSE COST CENTERS		0		0	0	0	117.00
200.00	Subtotal (see instructions)		15,699,417	0	15,699,417	0	15,699,417	200.00
201.00	Less Observation Beds		0		0	0	0	201.00
202.00	Total (see instructions)		15,699,417	0	15,699,417	0	15,699,417	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 4/30/2024 11:02 am
		Title XIX	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	9,875,250		9,875,250			30.00
44.00 04400 SKILLED NURSING FACILITY	0		0			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400 RADIOLOGY-DIAGNOSTIC	200,781	0	200,781	0.318750	0.000000	54.00
57.00 05700 CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00 06000 LABORATORY	1,343,835	0	1,343,835	0.089755	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	780,548	0	780,548	0.314451	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	2,368,715	907,660	3,276,375	0.525034	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	2,278,440	361,765	2,640,205	0.538177	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	821,210	191,380	1,012,590	0.506762	0.000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	308,627	0	308,627	1.016013	0.000000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2,900,644	0	2,900,644	0.221387	0.000000	73.00
74.00 07400 RENAL DIALYSIS	402,750	0	402,750	0.623124	0.000000	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100 EMERGENCY	0	0	0	0.000000	0.000000	91.00
91.01 04951 OUTPATIENT THERAPY	0	0	0	0.000000	0.000000	91.01
93.00 04950 OUTPATIENT WOUND CENTER	0	0	0	0.000000	0.000000	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00 10100 HOME HEALTH AGENCY	0	0	0			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
117.00 06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0			117.00
200.00 Subtotal (see instructions)	21,280,800	1,460,805	22,741,605			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	21,280,800	1,460,805	22,741,605			202.00



COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 4/30/2024 11:02 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital
		11.00		PPS
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
44.00	04400 SKILLED NURSING FACILITY			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.318750		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000 LABORATORY	0.089755		60.00
65.00	06500 RESPIRATORY THERAPY	0.314451		65.00
66.00	06600 PHYSICAL THERAPY	0.525034		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.538177		67.00
68.00	06800 SPEECH PATHOLOGY	0.506762		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.016013		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.221387		73.00
74.00	07400 RENAL DIALYSIS	0.623124		74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	09100 EMERGENCY	0.000000		91.00
91.01	04951 OUTPATIENT THERAPY	0.000000		91.01
93.00	04950 OUTPATIENT WOUND CENTER	0.000000		93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
101.00	10100 HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
117.00	06950 OTHER SPECIAL PURPOSE COST CENTERS			117.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 15-3042

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

Worksheet C Part II Date/Time Prepared: 4/30/2024 11:02 am

Cost Center Description		Title XIX			Hospital		PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	63,999	974	63,025	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	120,616	3,343	117,273	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	245,444	17,510	227,934	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,720,209	255,908	1,464,301	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,420,898	148,947	1,271,951	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	513,142	22,220	490,922	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	313,569	35,096	278,473	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	642,165	49,406	592,759	0	0	73.00
74.00	07400	RENAL DIALYSIS	250,963	3,223	247,740	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	25,595	265	25,330	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
200.00		Subtotal (sum of lines 50 thru 199)	5,316,600	536,892	4,779,708	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	5,316,600	536,892	4,779,708	0	0	202.00

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

Provider CCN: 15-3042

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

Worksheet C Part II Date/Time Prepared: 4/30/2024 11:02 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
		6.00	7.00	8.00		
Title XIX Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	63,999	200,781	0.318750	54.00
57.00	05700	CT SCAN	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	58.00
60.00	06000	LABORATORY	120,616	1,343,835	0.089755	60.00
65.00	06500	RESPIRATORY THERAPY	245,444	780,548	0.314451	65.00
66.00	06600	PHYSICAL THERAPY	1,720,209	3,276,375	0.525034	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,420,898	2,640,205	0.538177	67.00
68.00	06800	SPEECH PATHOLOGY	513,142	1,012,590	0.506762	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	313,569	308,627	1.016013	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	642,165	2,900,644	0.221387	73.00
74.00	07400	RENAL DIALYSIS	250,963	402,750	0.623124	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	25,595	0	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0.000000	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0.000000	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000	101.00
SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0.000000	117.00
200.00		Subtotal (sum of lines 50 thru 199)	5,316,600	12,866,355		200.00
201.00		Less Observation Beds	0	0		201.00
202.00		Total (line 200 minus line 201)	5,316,600	12,866,355		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-3042		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part I Date/Time Prepared: 4/30/2024 11:02 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	1,785,354	0	1,785,354	9,432	189.29	30.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	1,785,354		1,785,354	9,432		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	4,701	889,852				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (lines 30 through 199)	4,701	889,852				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prepared: 4/30/2024 11:02 am
--	-----------------------	---	---

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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400 RADIOLOGY-DIAGNOSTIC	974	200,781	0.004851	97,514	473	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000 LABORATORY	3,343	1,343,835	0.002488	692,086	1,722	60.00
65.00	06500 RESPIRATORY THERAPY	17,510	780,548	0.022433	437,096	9,805	65.00
66.00	06600 PHYSICAL THERAPY	255,908	3,276,375	0.078107	1,207,875	94,343	66.00
67.00	06700 OCCUPATIONAL THERAPY	148,947	2,640,205	0.056415	1,146,310	64,669	67.00
68.00	06800 SPEECH PATHOLOGY	22,220	1,012,590	0.021944	375,205	8,233	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	35,096	308,627	0.113717	119,089	13,542	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	49,406	2,900,644	0.017033	1,510,792	25,733	73.00
74.00	07400 RENAL DIALYSIS	3,223	402,750	0.008002	249,150	1,994	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	265	0	0.000000	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	0	0	0.000000	0	0	91.00
91.01	04951 OUTPATIENT THERAPY	0	0	0.000000	0	0	91.01
93.00	04950 OUTPATIENT WOUND CENTER	0	0	0.000000	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	536,892	12,866,355		5,835,117	220,514	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-3042		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part III Date/Time Prepared: 4/30/2024 11:02 am		
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
Title XVIII			Hospital		Hospital		PPS		
Cost Center Description			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	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00	
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	9,432	0.00	4,701	30.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0	44.00	
200.00		Total (lines 30 through 199)	0	0	9,432	0.00	4,701	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
44.00	04400	SKILLED NURSING FACILITY	0						44.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 4/30/2024 11:02 am
--	-----------------------	---	---

Cost Center Description	Title XVIII					Hospital		
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	PPS		
	1.00	2A	2.00	3A	3.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 4/30/2024 11:02 am
--	-----------------------	---	---

Cost Center Description	Title XVIII		Hospital		PPS			
	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)			
	4.00	5.00	6.00	7.00	8.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	200,781	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	1,343,835	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	780,548	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,276,375	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,640,205	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,012,590	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	308,627	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,900,644	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	402,750	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0.000000	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0.000000	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	12,866,355		200.00



APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 4/30/2024 11:02 am
--	-----------------------	---	---

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	97,514	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	692,086	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	437,096	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,207,875	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,146,310	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	375,205	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	119,089	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,510,792	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	249,150	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0.000000	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		5,835,117	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 4/30/2024 11:02 am
Title XVIII		Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.318750	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.089755	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.314451	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.525034	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.538177	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.506762	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.016013	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.221387	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.623124	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0.000000	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 4/30/2024 11:02 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00 05700	CT SCAN	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00 06000	LABORATORY	0	0	60.00
65.00 06500	RESPIRATORY THERAPY	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00 09100	EMERGENCY	0	0	91.00
91.01 04951	OUTPATIENT THERAPY	0	0	91.01
93.00 04950	OUTPATIENT WOUND CENTER	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 09500	AMBULANCE SERVICES	0	0	95.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00	Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-3042		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part I Date/Time Prepared: 4/30/2024 11:02 am		
Cost Center Description		Title XIX		Hospital		PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,785,354	0	1,785,354	9,432	189.29	30.00	
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00	
200.00	Total (lines 30 through 199)	1,785,354		1,785,354	9,432		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	42	7,950					30.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
200.00	Total (lines 30 through 199)	42	7,950					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prepared: 4/30/2024 11:02 am
--	-----------------------	---	---

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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400 RADIOLOGY-DIAGNOSTIC	974	200,781	0.004851	786	4	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000 LABORATORY	3,343	1,343,835	0.002488	5,044	13	60.00
65.00	06500 RESPIRATORY THERAPY	17,510	780,548	0.022433	432	10	65.00
66.00	06600 PHYSICAL THERAPY	255,908	3,276,375	0.078107	8,195	640	66.00
67.00	06700 OCCUPATIONAL THERAPY	148,947	2,640,205	0.056415	11,570	653	67.00
68.00	06800 SPEECH PATHOLOGY	22,220	1,012,590	0.021944	4,330	95	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	35,096	308,627	0.113717	4,724	537	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	49,406	2,900,644	0.017033	10,415	177	73.00
74.00	07400 RENAL DIALYSIS	3,223	402,750	0.008002	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	265	0	0.000000	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	0	0	0.000000	0	0	91.00
91.01	04951 OUTPATIENT THERAPY	0	0	0.000000	0	0	91.01
93.00	04950 OUTPATIENT WOUND CENTER	0	0	0.000000	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	536,892	12,866,355		45,496	2,129	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-3042		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part III Date/Time Prepared: 4/30/2024 11:02 am		
Cost Center Description			Title XIX		Hospital		PPS		
			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00	
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	9,432	0.00	42	30.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0	44.00	
200.00		Total (lines 30 through 199)	0	0	9,432	0.00	42	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
44.00	04400	SKILLED NURSING FACILITY	0						44.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 4/30/2024 11:02 am
--	-----------------------	---	---

Cost Center Description	Title XIX				Hospital			
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	PPS		
	1.00	2A	2.00	3A	3.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 4/30/2024 11:02 am
--	-----------------------	---	---

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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	200,781	0.000000	54.00
57.00 05700 CT SCAN	0	0	0	0	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00 06000 LABORATORY	0	0	0	1,343,835	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	780,548	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	3,276,375	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	2,640,205	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	1,012,590	0.000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	308,627	0.000000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	2,900,644	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	402,750	0.000000	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100 EMERGENCY	0	0	0	0	0.000000	91.00
91.01 04951 OUTPATIENT THERAPY	0	0	0	0	0.000000	91.01
93.00 04950 OUTPATIENT WOUND CENTER	0	0	0	0	0.000000	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0	0	12,866,355		200.00



APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 4/30/2024 11:02 am
--	-----------------------	---	---

Cost Center Description		Title XIX			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	786	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	5,044	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	432	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	8,195	0	86,905	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	11,570	0	58,730	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	4,330	0	16,380	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	4,724	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	10,415	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0.000000	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		45,496	0	162,015	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 4/30/2024 11:02 am
	Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0.318750	0	0	0	54.00
57.00 05700	CT SCAN	0.000000	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
60.00 06000	LABORATORY	0.089755	0	0	0	60.00
65.00 06500	RESPIRATORY THERAPY	0.314451	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0.525034	86,905	0	45,628	66.00
67.00 06700	OCCUPATIONAL THERAPY	0.538177	58,730	0	31,607	67.00
68.00 06800	SPEECH PATHOLOGY	0.506762	16,380	0	8,301	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.016013	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0.221387	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0.623124	0	0	0	74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	0.000000	0	0	0	91.00
91.01 04951	OUTPATIENT THERAPY	0.000000	0	0	0	91.01
93.00 04950	OUTPATIENT WOUND CENTER	0.000000	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0.000000	0	0	0	95.00
200.00	Subtotal (see instructions)		162,015	0	85,536	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		162,015	0	85,536	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 4/30/2024 11:02 am
	Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00 05700	CT SCAN	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00 06000	LABORATORY	0	0	60.00
65.00 06500	RESPIRATORY THERAPY	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00 09100	EMERGENCY	0	0	91.00
91.01 04951	OUTPATIENT THERAPY	0	0	91.01
93.00 04950	OUTPATIENT WOUND CENTER	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 09500	AMBULANCE SERVICES	0	0	95.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00	Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 4/30/2024 11:02 am
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		9,432	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		9,432	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		9,432	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		4,701	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
<b>SWING BED ADJUSTMENT</b>				
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)		10,382,817	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)		10,382,817	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		10,382,817	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,100.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,174,908	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		5,174,908	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 4/30/2024 11:02 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)					2,282,596 48.00
48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0 48.01
49.00 Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					7,457,504 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)					889,852 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					220,514 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,110,366 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,347,138 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
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3042		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 4/30/2024 11:02 am	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,785,354	10,382,817	0.171953	0	0	90.00
91.00	Nursing Program cost	0	10,382,817	0.000000	0	0	91.00
92.00	Allied health cost	0	10,382,817	0.000000	0	0	92.00
93.00	All other Medical Education	0	10,382,817	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 4/30/2024 11:02 am
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		9,432	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		9,432	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		9,432	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)		42	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
<b>SWING BED ADJUSTMENT</b>				
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)		10,382,817	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)		10,382,817	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		10,382,817	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,100.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		46,234	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		46,234	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 4/30/2024 11:02 am	
Cost Center Description			Title XIX		Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				20,670	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)				66,904	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				7,950	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				2,129	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				10,079	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				56,825	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
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0	89.00



COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-3042

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

Worksheet D-1  
Date/Time Prepared:  
4/30/2024 11:02 am

Cost Center Description	Cost	Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	1,785,354	10,382,817	0.171953	0	0	90.00
91.00 Nursing Program cost	0	10,382,817	0.000000	0	0	91.00
92.00 Allied health cost	0	10,382,817	0.000000	0	0	92.00
93.00 All other Medical Education	0	10,382,817	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 4/30/2024 11:02 am	
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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		4,936,050		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.318750	97,514	31,083	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.089755	692,086	62,118	60.00
65.00	06500 RESPIRATORY THERAPY	0.314451	437,096	137,445	65.00
66.00	06600 PHYSICAL THERAPY	0.525034	1,207,875	634,175	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.538177	1,146,310	616,918	67.00
68.00	06800 SPEECH PATHOLOGY	0.506762	375,205	190,140	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.016013	119,089	120,996	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.221387	1,510,792	334,470	73.00
74.00	07400 RENAL DIALYSIS	0.623124	249,150	155,251	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100 EMERGENCY	0.000000	0	0	91.00
91.01	04951 OUTPATIENT THERAPY	0.000000	0	0	91.01
93.00	04950 OUTPATIENT WOUND CENTER	0.000000	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		5,835,117	2,282,596	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)		5,835,117		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 4/30/2024 11:02 am	
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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		44,100		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.318750	786	251	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.089755	5,044	453	60.00
65.00	06500 RESPIRATORY THERAPY	0.314451	432	136	65.00
66.00	06600 PHYSICAL THERAPY	0.525034	8,195	4,303	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.538177	11,570	6,227	67.00
68.00	06800 SPEECH PATHOLOGY	0.506762	4,330	2,194	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.016013	4,724	4,800	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.221387	10,415	2,306	73.00
74.00	07400 RENAL DIALYSIS	0.623124	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100 EMERGENCY	0.000000	0	0	91.00
91.01	04951 OUTPATIENT THERAPY	0.000000	0	0	91.01
93.00	04950 OUTPATIENT WOUND CENTER	0.000000	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		45,496	20,670	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)		45,496		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 4/30/2024 11:02 am
		Title XVIII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	OPPS or REH payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
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 charge basis 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)			0 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)			0 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)			0 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
28.50	REH facility payment amount (see instructions)			0 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)			0 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			0 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			0 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			0 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (see instructions)			0 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)			0 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)			0 40.00
40.01	Sequestration adjustment (see instructions)			0 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
40.03	Sequestration adjustment-PARHM pass-throughs			0 40.03
41.00	Interim payments			0 41.00
41.01	Interim payments-PARHM			0 41.01
42.00	Tentative settlement (for contractors use only)			0 42.00
42.01	Tentative settlement-PARHM (for contractor use only)			0 42.01
43.00	Balance due provider/program (see instructions)			0 43.00
43.01	Balance due provider/program-PARHM (see instructions)			0 43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 4/30/2024 11:02 am
		Title XVIII	Hospital	PPS
				1.00
94.00	Total (sum of lines 91 and 93)			0 94.00
				1.00
200.00	MEDICARE PART B ANCILLARY COSTS Part B Combined Billed Days			0 200.00

Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part I Date/Time Prepared: 4/30/2024 11:02 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		8,551,153		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		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)		8,551,153		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		156,323		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		8,707,476		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part III Date/Time Prepared: 4/30/2024 11:02 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)		8,563,185	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0302	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		486,389	3.00
4.00	Outlier Payments		37,303	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	5.01
6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)		25.841096	10.00
11.00	Teaching Adjustment Factor (see instructions)		0.000000	11.00
12.00	Teaching Adjustment (see instructions)		0	12.00
13.00	Total PPS Payment (see instructions)		9,086,877	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		0	15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)		0	16.00
17.00	Subtotal (see instructions)		9,086,877	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		9,086,877	19.00
20.00	Deductibles		106,980	20.00
21.00	Subtotal (line 19 minus line 20)		8,979,897	21.00
22.00	Coinsurance		115,200	22.00
23.00	Subtotal (line 21 minus line 22)		8,864,697	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		31,512	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		20,483	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		24,371	26.00
27.00	Subtotal (sum of lines 23 and 25)		8,885,180	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	28.00
29.00	Other pass through costs (see instructions)		0	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	31.50
31.98	Recovery of accelerated depreciation.		0	31.98
31.99	Demonstration payment adjustment amount before sequestration		0	31.99
32.00	Total amount payable to the provider (see instructions)		8,885,180	32.00
32.01	Sequestration adjustment (see instructions)		177,704	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		8,551,153	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)		156,323	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4		37,303	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
<b>FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)</b>				
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

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

Provider CCN: 15-3042

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

Worksheet G

Date/Time Prepared:  
4/30/2024 11:02 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	58,792	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	2,872,843	0	0	0	4.00
5.00	Other receivable	85,547	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	104,740	0	0	0	6.00
7.00	Inventory	111,950	0	0	0	7.00
8.00	Prepaid expenses	338,991	0	0	0	8.00
9.00	Other current assets	8,388	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,581,251	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	0	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	10,703,267	0	0	0	15.00
16.00	Accumulated depreciation	-1,365,873	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	24,112	0	0	0	19.00
20.00	Accumulated depreciation	-20,704	0	0	0	20.00
21.00	Automobiles and trucks	61,836	0	0	0	21.00
22.00	Accumulated depreciation	-49,449	0	0	0	22.00
23.00	Major movable equipment	2,696,916	0	0	0	23.00
24.00	Accumulated depreciation	-2,344,162	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)	9,705,943	0	0	0	30.00
<b>OTHER ASSETS</b>						
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	229,473,503	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	229,473,503	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	242,760,697	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	379,668	0	0	0	37.00
38.00	Salaries, wages, and fees payable	537,857	0	0	0	38.00
39.00	Payroll taxes payable	82,191	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	245,087,599	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	246,087,315	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	176,995	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	9,656,301	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,833,296	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	255,920,611	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	-13,159,914	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-13,159,914	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	242,760,697	0	0	0	60.00



STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-3042

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

Worksheet G-1

Date/Time Prepared:  
4/30/2024 11:02 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		-14,052,212		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		892,298				2.00
3.00	Total (sum of line 1 and line 2)		-13,159,914		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)		-13,159,914		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-13,159,914		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

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	9,875,250		9,875,250	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	0		0	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)	9,875,250		9,875,250	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)	9,875,250		9,875,250	17.00
18.00	Ancillary services	11,405,550	1,460,805	12,866,355	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	21,280,800	1,460,805	22,741,605	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		15,052,833		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)		15,052,833		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-3042

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

Worksheet G-3

Date/Time Prepared:  
4/30/2024 11:02 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	22,741,605	1.00
2.00	Less contractual allowances and discounts on patients' accounts	6,950,285	2.00
3.00	Net patient revenues (line 1 minus line 2)	15,791,320	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	15,052,833	4.00
5.00	Net income from service to patients (line 3 minus line 4)	738,487	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-1,767	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	6,690	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	120	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	MISC INC, TRANSPORT, EMP PHYS SVCS	148,768	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	153,811	25.00
26.00	Total (line 5 plus line 25)	892,298	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	892,298	29.00