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: 15-0006	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/30/2024 2:17 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/30/2024 Time: 2:17 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LAPORTE HOSPITAL (15-0006) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title				3
4	Date				4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	216,029	-47,201	0	90	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	216,029	-47,201	0	90	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: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 2:17 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: STATE & MADISON STREETS	PO Box: 250			1.00
2.00	City: LAPORTE	State: IN	Zip Code: 46350-	County: LA PORTE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	LAPORTE HOSPITAL	150006	33140	1	07/01/1966	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	LAPORTE HOSPITAL COMPANY LLC	15U006	33140		03/01/2020	N	P	P	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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	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.	Y	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		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: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2024 2:17 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	637	207	0	3	4,422	215	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 2:17 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 2:17 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0006	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 2:17 pm

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

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		Y	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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2024 2:17 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	96,683	66,977	0	118.01

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

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: COMMUNITY HEALTH SYSTEMS	Contractor's Name: WPS	Contractor's Number: 10101	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	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: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 2:17 pm

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2024 2:17 pm

			Y/N	Date	
			1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE				
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/24/2024	Y	05/24/2024 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: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2024 2:17 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			Y	12/31/2022	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JOE		MARKIN		41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-506-6017		JOE_MARKIN@CHS.NET		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0006	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/30/2024 2:17 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REVENUE 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: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2024 2:17 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	60	21,900	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		60	21,900	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	14	5,110	0.00	0	8.00
8.01	NEONATAL ICU	31.01	10	3,650	0.00	0	8.01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		84	30,660	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		84				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: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2024 2:17 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,343	519	16,646			1.00
2.00	HMO and other (see instructions)	5,106	3,490				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	5	0	16			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,348	519	16,662			7.00
8.00	INTENSIVE CARE UNIT	704	31	2,240			8.00
8.01	NEONATAL ICU	0	0	196			8.01
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		1,229	1,320			13.00
14.00	Total (see instructions)	6,052	1,779	20,418	0.00	573.57	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			3			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	573.57	27.00
28.00	Observation Bed Days		0	1,516			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			246			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	215	317			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: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2024 2:17 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,321	1,097	4,366	1.00
2.00	HMO and other (see instructions)			993	0		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
8.01	NEONATAL ICU						8.01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,321	1,097	4,366	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2024 2:17 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	46,170,707	0	46,170,707	1,193,035.00	38.70	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		142,892	0	142,892	688.00	207.69	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		205,930	0	205,930	6,324.00	32.56	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,825,879	0	1,825,879	30,436.00	59.99	11.00
12.00	Contract labor: Top level management and other management and administrative services		21,297	0	21,297	324.00	65.73	12.00
13.00	Contract labor: Physician-Part A - Administrative		1,145,199	0	1,145,199	5,492.00	208.52	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		6,304,063	0	6,304,063	169,029.00	37.30	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		13,064,172	0	13,064,172			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		67,131	0	67,131			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		9,977	0	9,977			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		1,476,823	0	1,476,823			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2024 2:17 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	304,450	0	304,450	9,004.00	33.81	26.00
27.00	Administrative & General	5.00	8,879,059	-651,259	8,227,800	213,188.00	38.59	27.00
28.00	Administrative & General under contract (see inst.)		94,057	0	94,057	820.00	114.70	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,076,382	0	1,076,382	36,503.00	29.49	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,157,055	0	1,157,055	55,986.00	20.67	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,029,800	0	1,029,800	39,287.62	26.21	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,783,685	191,072	2,974,757	68,679.00	43.31	38.00
39.00	Central Services and Supply	14.00	608,964	0	608,964	24,762.00	24.59	39.00
40.00	Pharmacy	15.00	1,576,383	0	1,576,383	33,092.00	47.64	40.00
41.00	Medical Records & Medical Records Library	16.00	470,655	0	470,655	17,523.00	26.86	41.00
42.00	Social Service	17.00	564,087	29,928	594,015	15,249.00	38.95	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part III Date/Time Prepared: 5/30/2024 2:17 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		48,451,619	0	48,451,619	1,289,128.62	37.58	1.00
2.00	Excluded area salaries (see instructions)		205,930	0	205,930	6,324.00	32.56	2.00
3.00	Subtotal salaries (line 1 minus line 2)		48,245,689	0	48,245,689	1,282,804.62	37.61	3.00
4.00	Subtotal other wages & related costs (see inst.)		9,296,438	0	9,296,438	205,281.00	45.29	4.00
5.00	Subtotal wage-related costs (see inst.)		14,550,972	0	14,550,972	0.00	30.16	5.00
6.00	Total (sum of lines 3 thru 5)		72,093,099	0	72,093,099	1,488,085.62	48.45	6.00
7.00	Total overhead cost (see instructions)		18,544,577	-430,259	18,114,318	514,093.62	35.24	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part IV Date/Time Prepared: 5/30/2024 2:17 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	887,202	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	8,410,283	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	107,143	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	31,662	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-130	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	96,544	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	213,563	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,681,068	17.00
18.00	Medicare Taxes - Employers Portion Only	627,024	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	86,920	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	13,141,279	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part V | Date/Time Prepared: 5/30/2024 2:17 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,825,879	13,141,279	1.00
2.00	Hospital	1,825,879	13,141,279	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0006	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/30/2024 2:17 pm

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.171820	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	34,030,528	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	174,056,698	6.00
7.00	Medicaid cost (line 1 times line 6)	29,906,422	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	7,448,650	22,532	7,471,182	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,279,827	22,532	1,302,359	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	1,279,827	22,532	1,302,359	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	6,531,174	26.00
27.00	Medicare reimbursable bad debts (see instructions)	185,267	27.00
27.01	Medicare allowable bad debts (see instructions)	285,026	27.01
28.00	Non-Medicare bad debt amount (see instructions)	6,246,148	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	1,172,972	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	2,475,331	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,475,331	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0006	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/30/2024 2:17 pm

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.171820	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		5.00
6.00	Medicaid charges		6.00
7.00	Medicaid cost (line 1 times line 6)		7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP		9.00
10.00	Stand-alone CHIP charges		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	7,448,650	22,532	7,471,182	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,279,827	22,532	1,302,359	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	1,279,827	22,532	1,302,359	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	6,529,813	26.00
27.00	Medicare reimbursable bad debts (see instructions)	185,267	27.00
27.01	Medicare allowable bad debts (see instructions)	285,026	27.01
28.00	Non-Medicare bad debt amount (see instructions)	6,244,787	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	1,172,738	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	2,475,097	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,475,097	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/30/2024 2:17 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		-1,530,155	-1,530,155	3,385,671	1,855,516	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		11,784,779	11,784,779	246,541	12,031,320	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	304,450	148,431	452,881	10,058,934	10,511,815	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,879,059	38,520,828	47,399,887	-15,283,989	32,115,898	5.00
7.00	00700	OPERATION OF PLANT	1,076,382	2,627,147	3,703,529	4,457,511	8,161,040	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	543,915	543,915	0	543,915	8.00
9.00	00900	HOUSEKEEPING	0	2,359,629	2,359,629	-485	2,359,144	9.00
10.00	01000	DIETARY	0	3,522,019	3,522,019	-2,153,460	1,368,559	10.00
11.00	01100	CAFETERIA	0	0	0	2,067,829	2,067,829	11.00
13.00	01300	NURSING ADMINISTRATION	2,783,685	402,850	3,186,535	167,292	3,353,827	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	608,964	8,467,268	9,076,232	-7,879,865	1,196,367	14.00
15.00	01500	PHARMACY	1,576,383	12,049,877	13,626,260	-11,789,120	1,837,140	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	470,655	812,904	1,283,559	-765	1,282,794	16.00
17.00	01700	SOCIAL SERVICE	564,087	144,509	708,596	32,782	741,378	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,412,818	4,404,405	10,817,223	1,202,006	12,019,229	30.00
31.00	03100	INTENSIVE CARE UNIT	2,067,306	1,534,112	3,601,418	-24,909	3,576,509	31.00
31.01	03101	NEONATAL ICU	498	42	540	70,932	71,472	31.01
43.00	04300	NURSERY	0	0	0	416,732	416,732	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,385,562	4,959,431	7,344,993	-1,307,481	6,037,512	50.00
51.00	05100	RECOVERY ROOM	1,542,358	283,386	1,825,744	-2,042	1,823,702	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,777,059	421,063	2,198,122	-1,276,928	921,194	52.00
53.00	05300	ANESTHESIOLOGY	48,482	2,971,278	3,019,760	-21,666	2,998,094	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,093,466	1,289,229	3,382,695	-666,404	2,716,291	54.00
54.01	05401	ULTRASOUND	409,154	60,435	469,589	-14,173	455,416	54.01
56.00	05600	RADIOISOTOPE	391,662	332,844	724,506	-55,075	669,431	56.00
57.00	05700	CT SCAN	648,110	316,389	964,499	-182,286	782,213	57.00
58.00	05800	MRI	231,678	147,936	379,614	-106,543	273,071	58.00
60.00	06000	LABORATORY	2,388,281	3,659,459	6,047,740	-845,260	5,202,480	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	615,070	615,070	62.00
65.00	06500	RESPIRATORY THERAPY	951,730	228,093	1,179,823	-74,579	1,105,244	65.00
66.00	06600	PHYSICAL THERAPY	1,657,331	290,115	1,947,446	-54,365	1,893,081	66.00
67.00	06700	OCCUPATIONAL THERAPY	544,453	68,255	612,708	-2,376	610,332	67.00
68.00	06800	SPEECH PATHOLOGY	439,295	58,331	497,626	-2,864	494,762	68.00
69.00	06900	ELECTROCARDIOLOGY	2,915,935	1,966,658	4,882,593	-704,876	4,177,717	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,617,354	1,617,354	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,011,600	6,011,600	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,416,043	11,416,043	73.00
74.00	07400	RENAL DIALYSIS	253,830	99,600	353,430	-10,994	342,436	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	253,010	76,544	329,554	-20,292	309,262	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	3,249	724,557	727,806	-737	727,069	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	4,515,201	4,515,201	0	4,515,201	90.00
91.00	09100	EMERGENCY	2,285,845	717,064	3,002,909	-21,807	2,981,102	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,964,777	108,978,428	154,943,205	-737,044	154,206,161	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	133,128	-588,840	-455,712	737,183	281,471	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	72,802	9,193	81,995	-139	81,856	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	46,170,707	108,398,781	154,569,488	0	154,569,488	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/30/2024 2:17 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-274,220	1,581,296		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	162,707	12,194,027		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,511,815		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,871,786	37,987,684		5.00
7.00	00700	OPERATION OF PLANT	-30,020	8,131,020		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	543,915		8.00
9.00	00900	HOUSEKEEPING	0	2,359,144		9.00
10.00	01000	DIETARY	0	1,368,559		10.00
11.00	01100	CAFETERIA	0	2,067,829		11.00
13.00	01300	NURSING ADMINISTRATION	-147,604	3,206,223		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,196,367		14.00
15.00	01500	PHARMACY	0	1,837,140		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-18,342	1,264,452		16.00
17.00	01700	SOCIAL SERVICE	0	741,378		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,699,659	9,319,570		30.00
31.00	03100	INTENSIVE CARE UNIT	-951,964	2,624,545		31.00
31.01	03101	NEONATAL ICU	0	71,472		31.01
43.00	04300	NURSERY	0	416,732		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-914,110	5,123,402		50.00
51.00	05100	RECOVERY ROOM	0	1,823,702		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-29,217	891,977		52.00
53.00	05300	ANESTHESIOLOGY	-2,792,411	205,683		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-51,266	2,665,025		54.00
54.01	05401	ULTRASOUND	0	455,416		54.01
56.00	05600	RADIOISOTOPE	0	669,431		56.00
57.00	05700	CT SCAN	0	782,213		57.00
58.00	05800	MRI	0	273,071		58.00
60.00	06000	LABORATORY	0	5,202,480		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	615,070		62.00
65.00	06500	RESPIRATORY THERAPY	0	1,105,244		65.00
66.00	06600	PHYSICAL THERAPY	0	1,893,081		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	610,332		67.00
68.00	06800	SPEECH PATHOLOGY	0	494,762		68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,177,717		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-39,045	1,578,309		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,011,600		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-12,220	11,403,823		73.00
74.00	07400	RENAL DIALYSIS	0	342,436		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0		76.00
76.01	03610	SLEEP LAB	0	309,262		76.01
76.02	03020	ACUPUNCTURE	0	0		76.02
76.03	03040	WOUND CARE	49,490	776,559		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-4,515,201	0		90.00
91.00	09100	EMERGENCY	-195,506	2,785,596		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,586,802	147,619,359		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	281,471		192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	81,856		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,586,802	147,982,686		200.00

RECLASSIFICATIONS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/30/2024 2:17 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	10,065,419	1.00
	0		0	10,065,419	
	B - RENTAL AND LEASE EXPENSES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,258,715	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	226,883	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,266	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
	0		0	4,486,864	
	C - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	420,672	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	805,679	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	19,658	3.00
	0		0	1,246,009	
	D - REPAIRS AND MAINTENANCE				
1.00	OPERATION OF PLANT	7.00	0	2,983,868	1.00
2.00	WOUND CARE	76.03	0	348	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
	0		0	2,984,216	
	E - CHIEF NURSING OFFICER COSTS				
1.00	NURSING ADMINISTRATION	13.00	191,072	0	1.00
	0		191,072	0	
	F - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,617,354	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	6,011,600	2.00
	0		0	7,628,954	
	G - COST OF DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,416,043	1.00
	0		0	11,416,043	
	H - LABOR AND DELIVERY COSTS				
1.00	ADULTS & PEDIATRICS	30.00	621,095	146,326	1.00
2.00	NEONATAL ICU	31.01	57,252	13,680	2.00
3.00	NURSERY	43.00	336,725	80,007	3.00

RECLASSIFICATIONS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/30/2024 2:17 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	0		1,015,072	240,013		
	I - CAFETERIA RECLASSIFICATION					
1.00	CAFETERIA	11.00	0	2,067,829		1.00
	0		0	2,067,829		
	J - NONCAPITALIZED EQUIPMENT					
1.00	OPERATION OF PLANT	7.00	0	341,788		1.00
2.00	HOUSEKEEPING	9.00	0	321		2.00
3.00	OPERATING ROOM	50.00	0	89,372		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
	0		0	431,481		
	K - BLOOD BANK RECLASSIFICATION					
1.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	134,575	480,495		1.00
	0		134,575	480,495		
	L - MOB OVERHEAD					
1.00	OPERATION OF PLANT	7.00	0	1,166,043		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	928,855		2.00
	0		0	2,094,898		
	M - SITTER COST					
1.00	ADULTS & PEDIATRICS	30.00	430,259	33,203		1.00
	TOTALS		430,259	33,203		
	N - CONTINUUM OF CARE					
1.00	SOCIAL SERVICE	17.00	29,928	3,036		1.00
	TOTALS		29,928	3,036		
	O - INTEREST EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,497		1.00
	TOTALS		0	4,497		
500.00	Grand Total: Increases		1,800,906	43,182,957		500.00

RECLASSIFICATIONS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/30/2024 2:17 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	10,065,419	0		1.00
	0		0	10,065,419			
	B - RENTAL AND LEASE EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,141,757	10		1.00
2.00	OPERATION OF PLANT	7.00	0	34,188	10		2.00
3.00	HOUSEKEEPING	9.00	0	805	0		3.00
4.00	DIETARY	10.00	0	3,122	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	19,196	0		5.00
6.00	PHARMACY	15.00	0	306,001	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	16,369	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	12,946	0		8.00
9.00	OPERATING ROOM	50.00	0	737,271	0		9.00
10.00	RECOVERY ROOM	51.00	0	7	0		10.00
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,320	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,348	0		12.00
13.00	LABORATORY	60.00	0	104,315	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	63,276	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	320	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	34,675	0		16.00
17.00	SLEEP LAB	76.01	0	7,370	0		17.00
18.00	EMERGENCY	91.00	0	424	0		18.00
19.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,154	0		19.00
	0		0	4,486,864			
	C - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,246,009	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	1,246,009			
	D - REPAIRS AND MAINTENANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	101,991	0		1.00
2.00	HOUSEKEEPING	9.00	0	1	0		2.00
3.00	DIETARY	10.00	0	77,264	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	2,104	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	133,200	0		5.00
6.00	PHARMACY	15.00	0	65,136	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	5,564	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	7,322	0		8.00
9.00	OPERATING ROOM	50.00	0	558,041	0		9.00
10.00	RECOVERY ROOM	51.00	0	1,090	0		10.00
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	7,619	0		11.00
12.00	ANESTHESIOLOGY	53.00	0	17,634	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	651,371	0		13.00
14.00	ULTRASOUND	54.01	0	14,173	0		14.00
15.00	RADIOISOTOPE	56.00	0	55,075	0		15.00
16.00	CT SCAN	57.00	0	181,023	0		16.00
17.00	MRI	58.00	0	104,557	0		17.00
18.00	LABORATORY	60.00	0	99,177	0		18.00
19.00	RESPIRATORY THERAPY	65.00	0	9,309	0		19.00
20.00	PHYSICAL THERAPY	66.00	0	40,561	0		20.00
21.00	OCCUPATIONAL THERAPY	67.00	0	1,214	0		21.00
22.00	SPEECH PATHOLOGY	68.00	0	1,318	0		22.00
23.00	ELECTROCARDIOLOGY	69.00	0	627,849	0		23.00
24.00	RENAL DIALYSIS	74.00	0	10,536	0		24.00
25.00	SLEEP LAB	76.01	0	12,568	0		25.00
26.00	EMERGENCY	91.00	0	14,455	0		26.00
27.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	184,064	0		27.00
	0		0	2,984,216			
	E - CHIEF NURSING OFFICER COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	191,072	0	0		1.00
	0		191,072	0			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	7,527,413	0		1.00
2.00	OPERATING ROOM	50.00	0	101,541	0		2.00
	0		0	7,628,954			
	G - COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	11,416,043	0		1.00
	0		0	11,416,043			
	H - LABOR AND DELIVERY COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1,015,072	240,013	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		1,015,072	240,013			

RECLASSIFICATIONS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/30/2024 2:17 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	I - CAFETERIA RECLASSIFICATION						
1.00	DIETARY	10.00	0	2,067,829	0		1.00
	0		0	2,067,829			
	J - NONCAPITALIZED EQUIPMENT						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,485	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	45,812	0		2.00
3.00	DIETARY	10.00	0	5,245	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	2,480	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	220,518	0		5.00
6.00	PHARMACY	15.00	0	1,940	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	765	0		7.00
8.00	SOCIAL SERVICE	17.00	0	182	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	6,944	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	4,641	0		10.00
11.00	RECOVERY ROOM	51.00	0	945	0		11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	12,904	0		12.00
13.00	ANESTHESIOLOGY	53.00	0	4,032	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	13,685	0		14.00
15.00	CT SCAN	57.00	0	1,263	0		15.00
16.00	MRI	58.00	0	1,986	0		16.00
17.00	LABORATORY	60.00	0	26,698	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	1,994	0		18.00
19.00	PHYSICAL THERAPY	66.00	0	13,484	0		19.00
20.00	OCCUPATIONAL THERAPY	67.00	0	1,162	0		20.00
21.00	SPEECH PATHOLOGY	68.00	0	1,546	0		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	42,352	0		22.00
23.00	RENAL DIALYSIS	74.00	0	458	0		23.00
24.00	SLEEP LAB	76.01	0	354	0		24.00
25.00	WOUND CARE	76.03	0	1,085	0		25.00
26.00	EMERGENCY	91.00	0	6,928	0		26.00
27.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,454	0		27.00
28.00	OTHER NONREIMBURSABLE COSTS	194.00	0	139	0		28.00
	0		0	431,481			
	K - BLOOD BANK RECLASSIFICATION						
1.00	LABORATORY	60.00	134,575	480,495	0		1.00
	0		134,575	480,495			
	L - MOB OVERHEAD						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,094,898	10		1.00
2.00		0.00	0	0	0		2.00
	0		0	2,094,898			
	M - SITTER COST						
1.00	ADMINISTRATIVE & GENERAL	5.00	430,259	33,203	0		1.00
	TOTALS		430,259	33,203			
	N - CONTINUUM OF CARE						
1.00	ADMINISTRATIVE & GENERAL	5.00	29,928	3,036	0		1.00
	TOTALS		29,928	3,036			
	O - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,497	11		1.00
	TOTALS		0	4,497			
500.00	Grand Total: Decreases		1,800,906	43,182,957			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2024 2:17 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,046,255	0	0	0	68,932	1.00
2.00	Land Improvements	2,290,554	0	0	0	22,475	2.00
3.00	Buildings and Fixtures	136,086,008	0	0	0	1,945,530	3.00
4.00	Building Improvements	2,566,009	753,795	0	753,795	0	4.00
5.00	Fixed Equipment	4,293,609	0	0	0	47,185	5.00
6.00	Movable Equipment	35,497,332	0	0	0	562,917	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	183,779,767	753,795	0	753,795	2,647,039	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	183,779,767	753,795	0	753,795	2,647,039	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,977,323	0	1.00
2.00	Land Improvements	2,268,079	0	2.00
3.00	Buildings and Fixtures	134,140,478	0	3.00
4.00	Building Improvements	3,319,804	0	4.00
5.00	Fixed Equipment	4,246,424	0	5.00
6.00	Movable Equipment	34,934,415	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	181,886,523	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	181,886,523	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/30/2024 2:17 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	-1,530,155	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,784,779	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	10,254,624	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	-1,530,155		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	11,784,779		2.00
3.00	Total (sum of lines 1-2)	0	10,254,624		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III Date/Time Prepared: 5/30/2024 2:17 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	146,952,107	0	146,952,107	0.807933	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	34,934,415	0	34,934,415	0.192067	0	2.00
3.00	Total (sum of lines 1-2)	181,886,522	0	181,886,522	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	-1,530,155	2,163,817	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	11,784,779	205,403	2.00
3.00	Total (sum of lines 1-2)	0	0	0	10,254,624	2,369,220	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	-278,717	420,672	805,679	0	1,581,296	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	184,187	19,658	0	0	12,194,027	2.00
3.00	Total (sum of lines 1-2)	-94,530	440,330	805,679	0	13,775,323	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/30/2024 2:17 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		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	0	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-30,020	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	-14,153,226			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	6,342,875			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-39,045	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-12,220	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-18,342	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	B	0	ADMINISTRATIVE & GENERAL	5.00	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)	A	-2,466	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	TRAINING REVENUE	B	-147,604	NURSING ADMINISTRATION	13.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/30/2024 2:17 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34.00	TELEPHONE COMMISSION	B	-68,794	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	MISC NON-PATIENT REVENUE	B	-69,658	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	RENTAL INCOME	B	-407,097	CAP REL COSTS-BLDG & FIXT	1.00	11	36.00
37.00	OTHER MISCELLANEOUS REVENUE	B	-224,165	ADMINISTRATIVE & GENERAL	5.00	0	37.00
39.00	MARKETING EXPENSE	A	-104,992	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	MGMT FEE AND MOB GAIN/LOSS	A	2,586,458	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	PHYSICIAN RECRUITING	A	-139,276	ADMINISTRATIVE & GENERAL	5.00	0	41.00
41.04	NONALLOWABLE EXPENSE - LOBBYING	A	-4,364	ADMINISTRATIVE & GENERAL	5.00	0	41.04
42.00	CHARITABLE CONTRIBUTIONS	A	-20,950	ADMINISTRATIVE & GENERAL	5.00	0	42.00
45.00	LEGAL FEES	A	-16,606	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.02	INTEREST INCOME ADD-BACK	A	4,497	CAP REL COSTS-MVBLE EQUIP	2.00	10	45.02
45.09	PATIENT TV DEPRECIATION	A	-25,977	CAP REL COSTS-MVBLE EQUIP	2.00	10	45.09
45.12	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-35,830	ADMINISTRATIVE & GENERAL	5.00	0	45.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,586,802				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: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2024 2:17 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00			0	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Bldg &	869	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	PASI Capital Costs - Moveabl	1,862	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	PASI Operating Costs	546,402	458,026	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	Shared Service Center Alloca	3,343,258	1,443,076	4.03
4.04	1.00	CAP REL COSTS-BLDG & FIXT	New Capital - Building & Fix	132,008	0	4.04
4.05	2.00	CAP REL COSTS-MVBLE EQUIP	New Capital - Movable Equipm	182,325	0	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	Non-Capital Home Office Cost	4,946,219	0	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	Malpractice Costs	163,660	879,310	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	Interest Expense	0	-7,355,132	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	Management Fees	0	3,676,689	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	401K Fees	0	5,151	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	Audit Fees	0	136,218	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	Corporate Overhead Allocatio	0	2,989,060	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	HIIM Allocation	0	629,831	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	Contract Management	0	144,531	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	PASI Lien Unit Collection Fe	0	-33,032	4.15
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,316,603	2,973,728	5.00

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

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

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

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

6.00	B		0.00	CHS	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0006	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Date/Time Prepared: 5/30/2024 2:17 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	869	11		4.00
4.01	1,862	11		4.01
4.02	88,376	11		4.02
4.03	1,900,182	0		4.03
4.04	132,008	11		4.04
4.05	182,325	11		4.05
4.06	4,946,219	0		4.06
4.07	-715,650	0		4.07
4.08	7,355,132	0		4.08
4.09	-3,676,689	0		4.09
4.10	-5,151	0		4.10
4.11	-136,218	0		4.11
4.12	-2,989,060	0		4.12
4.13	-629,831	0		4.13
4.14	-144,531	0		4.14
4.15	33,032	0		4.15
5.00	6,342,875			5.00

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

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

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

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

6.00	HEALTHCARE		6.00
7.00	COLLECTION UNIT		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2024 2:17 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	2,055,848	2,055,848	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,697,193	2,697,193	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	951,964	951,964	0	0	0	3.00
4.00	50.00	OPERATING ROOM	914,110	914,110	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	29,217	29,217	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	2,792,411	2,792,411	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	51,266	51,266	0	0	0	7.00
8.00	76.03	WOUND CARE	-49,490	-49,490	0	0	0	8.00
9.00	90.00	CLINIC	4,515,201	4,515,201	0	0	0	9.00
10.00	91.00	EMERGENCY	195,506	195,506	0	0	0	10.00
200.00			14,153,226	14,153,226	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	76.03	WOUND CARE	0	0	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	2,055,848		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,697,193		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	951,964		3.00
4.00	50.00	OPERATING ROOM	0	0	0	914,110		4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	29,217		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	2,792,411		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	51,266		7.00
8.00	76.03	WOUND CARE	0	0	0	-49,490		8.00
9.00	90.00	CLINIC	0	0	0	4,515,201		9.00
10.00	91.00	EMERGENCY	0	0	0	195,506		10.00
200.00			0	0	0	14,153,226		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/30/2024 2:17 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,581,296	1,581,296				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	12,194,027		12,194,027			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	10,511,815	4,617	35,602	10,552,034		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	37,987,684	62,417	481,326	1,892,894	40,424,321	5.00
7.00	00700	OPERATION OF PLANT	8,131,020	988,562	7,623,216	247,634	16,990,432	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	543,915	1,614	12,444	0	557,973	8.00
9.00	00900	HOUSEKEEPING	2,359,144	5,742	44,277	0	2,409,163	9.00
10.00	01000	DIETARY	1,368,559	9,021	69,562	0	1,447,142	10.00
11.00	01100	CAFETERIA	2,067,829	5,707	44,006	0	2,117,542	11.00
13.00	01300	NURSING ADMINISTRATION	3,206,223	4,254	32,806	684,376	3,927,659	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,196,367	11,661	89,924	140,099	1,438,051	14.00
15.00	01500	PHARMACY	1,837,140	7,667	59,120	362,664	2,266,591	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,264,452	1,929	14,879	108,279	1,389,539	16.00
17.00	01700	SOCIAL SERVICE	741,378	1,420	10,947	136,660	890,405	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,319,570	86,968	670,643	1,717,215	11,794,396	30.00
31.00	03100	INTENSIVE CARE UNIT	2,624,545	26,863	207,153	475,606	3,334,167	31.00
31.01	03101	NEONATAL ICU	71,472	0	0	13,286	84,758	31.01
43.00	04300	NURSERY	416,732	255	1,966	77,467	496,420	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,123,402	55,078	424,731	548,825	6,152,036	50.00
51.00	05100	RECOVERY ROOM	1,823,702	5,379	41,481	354,836	2,225,398	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	891,977	35,559	274,209	175,303	1,377,048	52.00
53.00	05300	ANESTHESIOLOGY	205,683	861	6,637	11,154	224,335	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,665,025	52,737	406,678	481,625	3,606,065	54.00
54.01	05401	ULTRASOUND	455,416	1,618	12,480	94,130	563,644	54.01
56.00	05600	RADIOISOTOPE	669,431	2,652	20,452	90,106	782,641	56.00
57.00	05700	CT SCAN	782,213	2,669	20,578	149,105	954,565	57.00
58.00	05800	MRI	273,071	3,150	24,294	53,300	353,815	58.00
60.00	06000	LABORATORY	5,202,480	18,179	140,188	518,490	5,879,337	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	615,070	936	7,214	30,960	654,180	62.00
65.00	06500	RESPIRATORY THERAPY	1,105,244	2,687	20,723	218,956	1,347,610	65.00
66.00	06600	PHYSICAL THERAPY	1,893,081	46,864	361,391	381,287	2,682,623	66.00
67.00	06700	OCCUPATIONAL THERAPY	610,332	12,667	97,679	125,257	845,935	67.00
68.00	06800	SPEECH PATHOLOGY	494,762	8,544	65,883	101,065	670,254	68.00
69.00	06900	ELECTROCARDIOLOGY	4,177,717	50,204	387,146	670,843	5,285,910	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,578,309	0	0	0	1,578,309	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,011,600	0	0	0	6,011,600	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,403,823	0	0	0	11,403,823	73.00
74.00	07400	RENAL DIALYSIS	342,436	622	4,797	58,396	406,251	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	309,262	17,679	136,329	58,208	521,478	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	776,559	10,833	83,540	747	871,679	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,785,596	31,941	246,308	525,884	3,589,729	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	147,619,359	1,579,556	12,180,609	10,504,657	147,556,824	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,740	13,418	0	15,158	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	281,471	0	0	30,628	312,099	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	81,856	0	0	16,749	98,605	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	147,982,686	1,581,296	12,194,027	10,552,034	147,982,686	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/30/2024 2:17 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	40,424,321					5.00
7.00	00700	OPERATION OF PLANT	6,385,632	23,376,064				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	209,706	71,758	839,437			8.00
9.00	00900	HOUSEKEEPING	905,450	255,314	0	3,569,927		9.00
10.00	01000	DIETARY	543,888	401,119	0	62,127	2,454,276	10.00
11.00	01100	CAFETERIA	795,849	253,754	0	39,303	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,476,156	189,172	0	29,300	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	540,471	518,532	0	80,312	0	14.00
15.00	01500	PHARMACY	851,866	340,904	0	52,801	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	522,239	85,798	0	13,289	0	16.00
17.00	01700	SOCIAL SERVICE	334,646	63,127	0	9,777	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,432,759	3,867,153	204,287	598,961	1,940,109	30.00
31.00	03100	INTENSIVE CARE UNIT	1,253,100	1,194,517	123,508	185,012	188,207	31.00
31.01	03101	NEONATAL ICU	31,855	0	0	0	0	31.01
43.00	04300	NURSERY	186,573	11,336	0	1,756	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,312,157	2,449,144	197,578	379,334	0	50.00
51.00	05100	RECOVERY ROOM	836,385	239,195	22,256	37,047	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	517,544	1,581,180	0	244,900	0	52.00
53.00	05300	ANESTHESIOLOGY	84,313	38,271	0	5,928	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,355,289	2,345,042	55,327	363,210	0	54.00
54.01	05401	ULTRASOUND	211,838	71,966	4,328	11,146	0	54.01
56.00	05600	RADIOISOTOPE	294,145	117,933	0	18,266	0	56.00
57.00	05700	CT SCAN	358,760	118,661	0	18,379	0	57.00
58.00	05800	MRI	132,976	140,085	0	21,697	0	58.00
60.00	06000	LABORATORY	2,209,667	808,373	0	125,204	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	245,864	41,599	0	6,443	0	62.00
65.00	06500	RESPIRATORY THERAPY	506,480	119,493	0	18,508	0	65.00
66.00	06600	PHYSICAL THERAPY	1,008,226	2,083,904	0	322,764	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	317,933	563,251	0	87,239	0	67.00
68.00	06800	SPEECH PATHOLOGY	251,906	379,903	0	58,841	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,986,635	2,232,413	77,245	345,766	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	593,185	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,259,376	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,285,967	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	152,684	27,663	0	4,285	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	195,990	786,118	6,077	121,757	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	327,608	481,717	4,964	74,610	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,349,149	1,420,295	143,867	219,981	81,103	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,264,267	23,298,690	839,437	3,557,943	2,209,419	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,697	77,374	0	11,984	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	117,298	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	37,059	0	0	0	244,857	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	40,424,321	23,376,064	839,437	3,569,927	2,454,276	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/30/2024 2:17 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	3,206,448					11.00
13.00	01300	NURSING ADMINISTRATION	235,570	5,857,857				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	84,896	0	2,662,262			14.00
15.00	01500	PHARMACY	113,504	0	14,847	3,640,513		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	60,070	0	1,361	0	2,072,296	16.00
17.00	01700	SOCIAL SERVICE	54,077	0	489	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	651,206	2,250,645	129,596	0	154,477	30.00
31.00	03100	INTENSIVE CARE UNIT	161,232	791,245	43,081	0	26,512	31.00
31.01	03101	NEONATAL ICU	4,923	20,985	1,345	0	1,085	31.01
43.00	04300	NURSERY	28,608	123,478	7,843	0	6,328	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	230,505	402,906	286,596	0	329,690	50.00
51.00	05100	RECOVERY ROOM	132,196	510,969	29,362	0	56,879	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	64,707	279,422	17,748	0	14,321	52.00
53.00	05300	ANESTHESIOLOGY	7,491	111	28,904	0	78,771	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	169,151	170,962	24,804	0	93,910	54.00
54.01	05401	ULTRASOUND	26,539	1,574	2,705	0	23,682	54.01
56.00	05600	RADIOISOTOPE	24,756	3,768	43,259	0	31,784	56.00
57.00	05700	CT SCAN	60,426	14,963	14,899	0	105,395	57.00
58.00	05800	MRI	18,263	3,084	3,027	0	30,075	58.00
60.00	06000	LABORATORY	302,916	0	284,771	0	232,320	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	11,058	0	84,528	0	3,386	62.00
65.00	06500	RESPIRATORY THERAPY	82,970	0	13,354	0	28,032	65.00
66.00	06600	PHYSICAL THERAPY	136,762	0	2,723	0	42,145	66.00
67.00	06700	OCCUPATIONAL THERAPY	44,588	0	478	0	15,917	67.00
68.00	06800	SPEECH PATHOLOGY	39,452	0	715	0	11,871	68.00
69.00	06900	ELECTROCARDIOLOGY	217,235	343,139	85,297	0	162,295	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	275,715	0	39,427	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,167,851	0	94,450	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,640,513	338,848	73.00
74.00	07400	RENAL DIALYSIS	17,265	73,354	13,141	0	8,605	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	26,325	0	3,438	0	9,101	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	571	334	14,635	0	18,773	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	177,498	853,851	64,098	0	114,217	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,184,760	5,844,790	2,660,610	3,640,513	2,072,296	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,270	13,067	1,652	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	8,418	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,206,448	5,857,857	2,662,262	3,640,513	2,072,296	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/30/2024 2:17 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	1,352,521					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,103,522	27,127,111	0	27,127,111		30.00
31.00	03100	INTENSIVE CARE UNIT	148,498	7,449,079	0	7,449,079		31.00
31.01	03101	NEONATAL ICU	12,994	157,945	0	157,945		31.01
43.00	04300	NURSERY	87,507	949,849	0	949,849		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	12,739,946	0	12,739,946		50.00
51.00	05100	RECOVERY ROOM	0	4,089,687	0	4,089,687		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,096,870	0	4,096,870		52.00
53.00	05300	ANESTHESIOLOGY	0	468,124	0	468,124		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,183,760	0	8,183,760		54.00
54.01	05401	ULTRASOUND	0	917,422	0	917,422		54.01
56.00	05600	RADIOISOTOPE	0	1,316,552	0	1,316,552		56.00
57.00	05700	CT SCAN	0	1,646,048	0	1,646,048		57.00
58.00	05800	MRI	0	703,022	0	703,022		58.00
60.00	06000	LABORATORY	0	9,842,588	0	9,842,588		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,047,058	0	1,047,058		62.00
65.00	06500	RESPIRATORY THERAPY	0	2,116,447	0	2,116,447		65.00
66.00	06600	PHYSICAL THERAPY	0	6,279,147	0	6,279,147		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,875,341	0	1,875,341		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,412,942	0	1,412,942		68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,735,935	0	10,735,935		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,486,636	0	2,486,636		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,533,277	0	9,533,277		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,669,151	0	19,669,151		73.00
74.00	07400	RENAL DIALYSIS	0	703,248	0	703,248		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	1,670,284	0	1,670,284		76.01
76.02	03020	ACUPUNCTURE	0	0	0	0		76.02
76.03	03040	WOUND CARE	0	1,794,891	0	1,794,891		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	8,013,788	0	8,013,788		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,352,521	147,026,148	0	147,026,148		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	110,213	0	110,213		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	457,386	0	457,386		192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	388,939	0	388,939		194.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,352,521	147,982,686	0	147,982,686		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/30/2024 2:17 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,617	35,602	40,219	40,219	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	62,417	481,326	543,743	7,210	5.00
7.00	00700	OPERATION OF PLANT	0	988,562	7,623,216	8,611,778	944	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,614	12,444	14,058	0	8.00
9.00	00900	HOUSEKEEPING	0	5,742	44,277	50,019	0	9.00
10.00	01000	DIETARY	0	9,021	69,562	78,583	0	10.00
11.00	01100	CAFETERIA	0	5,707	44,006	49,713	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,254	32,806	37,060	2,609	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,661	89,924	101,585	534	14.00
15.00	01500	PHARMACY	0	7,667	59,120	66,787	1,382	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,929	14,879	16,808	413	16.00
17.00	01700	SOCIAL SERVICE	0	1,420	10,947	12,367	521	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	86,968	670,643	757,611	6,546	30.00
31.00	03100	INTENSIVE CARE UNIT	0	26,863	207,153	234,016	1,813	31.00
31.01	03101	NEONATAL ICU	0	0	0	0	51	31.01
43.00	04300	NURSERY	0	255	1,966	2,221	295	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	55,078	424,731	479,809	2,092	50.00
51.00	05100	RECOVERY ROOM	0	5,379	41,481	46,860	1,353	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	35,559	274,209	309,768	668	52.00
53.00	05300	ANESTHESIOLOGY	0	861	6,637	7,498	43	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	52,737	406,678	459,415	1,836	54.00
54.01	05401	ULTRASOUND	0	1,618	12,480	14,098	359	54.01
56.00	05600	RADIOISOTOPE	0	2,652	20,452	23,104	343	56.00
57.00	05700	CT SCAN	0	2,669	20,578	23,247	568	57.00
58.00	05800	MRI	0	3,150	24,294	27,444	203	58.00
60.00	06000	LABORATORY	0	18,179	140,188	158,367	1,977	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	936	7,214	8,150	118	62.00
65.00	06500	RESPIRATORY THERAPY	0	2,687	20,723	23,410	835	65.00
66.00	06600	PHYSICAL THERAPY	0	46,864	361,391	408,255	1,453	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,667	97,679	110,346	477	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,544	65,883	74,427	385	68.00
69.00	06900	ELECTROCARDIOLOGY	0	50,204	387,146	437,350	2,557	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	622	4,797	5,419	223	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	17,679	136,329	154,008	222	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	0	10,833	83,540	94,373	3	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	31,941	246,308	278,249	2,005	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,579,556	12,180,609	13,760,165	40,038	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,740	13,418	15,158	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	117	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	0	0	0	64	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,581,296	12,194,027	13,775,323	40,219	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/30/2024 2:17 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	550,953					5.00
7.00	00700	OPERATION OF PLANT	87,065	8,699,787				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,858	26,706	43,622			8.00
9.00	00900	HOUSEKEEPING	12,340	95,019	0	157,378		9.00
10.00	01000	DIETARY	7,412	149,283	0	2,739	238,017	10.00
11.00	01100	CAFETERIA	10,846	94,439	0	1,733	0	11.00
13.00	01300	NURSING ADMINISTRATION	20,117	70,403	0	1,292	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,366	192,980	0	3,541	0	14.00
15.00	01500	PHARMACY	11,609	126,873	0	2,328	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,117	31,931	0	586	0	16.00
17.00	01700	SOCIAL SERVICE	4,561	23,494	0	431	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	60,411	1,439,227	10,616	26,404	188,154	30.00
31.00	03100	INTENSIVE CARE UNIT	17,078	444,559	6,418	8,156	18,252	31.00
31.01	03101	NEONATAL ICU	434	0	0	0	0	31.01
43.00	04300	NURSERY	2,543	4,219	0	77	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,511	911,489	10,267	16,723	0	50.00
51.00	05100	RECOVERY ROOM	11,398	89,020	1,157	1,633	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,053	588,462	0	10,796	0	52.00
53.00	05300	ANESTHESIOLOGY	1,149	14,243	0	261	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,470	872,746	2,875	16,012	0	54.00
54.01	05401	ULTRASOUND	2,887	26,783	225	491	0	54.01
56.00	05600	RADIOISOTOPE	4,009	43,891	0	805	0	56.00
57.00	05700	CT SCAN	4,889	44,162	0	810	0	57.00
58.00	05800	MRI	1,812	52,135	0	956	0	58.00
60.00	06000	LABORATORY	30,114	300,849	0	5,520	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,351	15,482	0	284	0	62.00
65.00	06500	RESPIRATORY THERAPY	6,902	44,471	0	816	0	65.00
66.00	06600	PHYSICAL THERAPY	13,740	775,559	0	14,229	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,333	209,623	0	3,846	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,433	141,387	0	2,594	0	68.00
69.00	06900	ELECTROCARDIOLOGY	27,074	830,829	4,014	15,243	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,084	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,791	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,410	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,081	10,295	0	189	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,671	292,567	316	5,368	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	4,465	179,279	258	3,289	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	18,387	528,586	7,476	9,698	7,865	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	548,771	8,670,991	43,622	156,850	214,271	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	78	28,796	0	528	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,599	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	505	0	0	0	23,746	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	550,953	8,699,787	43,622	157,378	238,017	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/30/2024 2:17 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	156,731					11.00
13.00	01300	NURSING ADMINISTRATION	11,515	142,996				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,150	0	310,156			14.00
15.00	01500	PHARMACY	5,548	0	1,730	216,257		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,936	0	159	0	59,950	16.00
17.00	01700	SOCIAL SERVICE	2,643	0	57	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,830	54,938	15,098	0	4,465	30.00
31.00	03100	INTENSIVE CARE UNIT	7,881	19,316	5,019	0	766	31.00
31.01	03101	NEONATAL ICU	241	512	157	0	31	31.01
43.00	04300	NURSERY	1,398	3,014	914	0	183	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,267	9,836	33,389	0	9,529	50.00
51.00	05100	RECOVERY ROOM	6,462	12,474	3,421	0	1,644	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,163	6,821	2,068	0	414	52.00
53.00	05300	ANESTHESIOLOGY	366	3	3,367	0	2,277	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,268	4,173	2,890	0	2,714	54.00
54.01	05401	ULTRASOUND	1,297	38	315	0	684	54.01
56.00	05600	RADIOISOTOPE	1,210	92	5,040	0	919	56.00
57.00	05700	CT SCAN	2,954	365	1,736	0	3,046	57.00
58.00	05800	MRI	893	75	353	0	869	58.00
60.00	06000	LABORATORY	14,807	0	33,177	0	6,714	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	541	0	9,848	0	98	62.00
65.00	06500	RESPIRATORY THERAPY	4,056	0	1,556	0	810	65.00
66.00	06600	PHYSICAL THERAPY	6,685	0	317	0	1,218	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,179	0	56	0	460	67.00
68.00	06800	SPEECH PATHOLOGY	1,928	0	83	0	343	68.00
69.00	06900	ELECTROCARDIOLOGY	10,618	8,377	9,937	0	4,691	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	32,122	0	1,140	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	136,050	0	2,730	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	216,257	9,849	73.00
74.00	07400	RENAL DIALYSIS	844	1,791	1,531	0	249	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,287	0	401	0	263	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	28	8	1,705	0	543	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	8,676	20,844	7,468	0	3,301	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	155,671	142,677	309,964	216,257	59,950	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	649	319	192	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	411	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	156,731	142,996	310,156	216,257	59,950	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/30/2024 2:17 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	44,074					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,960	2,631,260	0	2,631,260		30.00
31.00	03100	INTENSIVE CARE UNIT	4,839	768,113	0	768,113		31.00
31.01	03101	NEONATAL ICU	423	1,849	0	1,849		31.01
43.00	04300	NURSERY	2,852	17,716	0	17,716		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,515,912	0	1,515,912		50.00
51.00	05100	RECOVERY ROOM	0	175,422	0	175,422		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	929,213	0	929,213		52.00
53.00	05300	ANESTHESIOLOGY	0	29,207	0	29,207		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,389,399	0	1,389,399		54.00
54.01	05401	ULTRASOUND	0	47,177	0	47,177		54.01
56.00	05600	RADIOISOTOPE	0	79,413	0	79,413		56.00
57.00	05700	CT SCAN	0	81,777	0	81,777		57.00
58.00	05800	MRI	0	84,740	0	84,740		58.00
60.00	06000	LABORATORY	0	551,525	0	551,525		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	37,872	0	37,872		62.00
65.00	06500	RESPIRATORY THERAPY	0	82,856	0	82,856		65.00
66.00	06600	PHYSICAL THERAPY	0	1,221,456	0	1,221,456		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	331,320	0	331,320		67.00
68.00	06800	SPEECH PATHOLOGY	0	224,580	0	224,580		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,350,690	0	1,350,690		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	41,346	0	41,346		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	169,571	0	169,571		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	284,516	0	284,516		73.00
74.00	07400	RENAL DIALYSIS	0	22,622	0	22,622		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	457,103	0	457,103		76.01
76.02	03020	ACUPUNCTURE	0	0	0	0		76.02
76.03	03040	WOUND CARE	0	283,951	0	283,951		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	892,555	0	892,555		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,074	13,703,161	0	13,703,161		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	44,560	0	44,560		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,876	0	2,876		192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	24,726	0	24,726		194.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	44,074	13,775,323	0	13,775,323		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 2:17 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	676,120					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		676,120				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,974	1,974	45,866,257			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,688	26,688	8,227,800	-40,424,321	107,558,365	5.00
7.00	00700	OPERATION OF PLANT	422,683	422,683	1,076,382	0	16,990,432	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	690	690	0	0	557,973	8.00
9.00	00900	HOUSEKEEPING	2,455	2,455	0	0	2,409,163	9.00
10.00	01000	DIETARY	3,857	3,857	0	0	1,447,142	10.00
11.00	01100	CAFETERIA	2,440	2,440	0	0	2,117,542	11.00
13.00	01300	NURSING ADMINISTRATION	1,819	1,819	2,974,757	0	3,927,659	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,986	4,986	608,964	0	1,438,051	14.00
15.00	01500	PHARMACY	3,278	3,278	1,576,383	0	2,266,591	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	825	825	470,655	0	1,389,539	16.00
17.00	01700	SOCIAL SERVICE	607	607	594,015	0	890,405	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,185	37,185	7,464,172	0	11,794,396	30.00
31.00	03100	INTENSIVE CARE UNIT	11,486	11,486	2,067,306	0	3,334,167	31.00
31.01	03101	NEONATAL ICU	0	0	57,750	0	84,758	31.01
43.00	04300	NURSERY	109	109	336,725	0	496,420	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,550	23,550	2,385,562	0	6,152,036	50.00
51.00	05100	RECOVERY ROOM	2,300	2,300	1,542,358	0	2,225,398	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,204	15,204	761,987	0	1,377,048	52.00
53.00	05300	ANESTHESIOLOGY	368	368	48,482	0	224,335	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,549	22,549	2,093,466	0	3,606,065	54.00
54.01	05401	ULTRASOUND	692	692	409,154	0	563,644	54.01
56.00	05600	RADIOISOTOPE	1,134	1,134	391,662	0	782,641	56.00
57.00	05700	CT SCAN	1,141	1,141	648,110	0	954,565	57.00
58.00	05800	MRI	1,347	1,347	231,678	0	353,815	58.00
60.00	06000	LABORATORY	7,773	7,773	2,253,706	0	5,879,337	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	400	400	134,575	0	654,180	62.00
65.00	06500	RESPIRATORY THERAPY	1,149	1,149	951,730	0	1,347,610	65.00
66.00	06600	PHYSICAL THERAPY	20,038	20,038	1,657,331	0	2,682,623	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,416	5,416	544,453	0	845,935	67.00
68.00	06800	SPEECH PATHOLOGY	3,653	3,653	439,295	0	670,254	68.00
69.00	06900	ELECTROCARDIOLOGY	21,466	21,466	2,915,935	0	5,285,910	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,578,309	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6,011,600	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	11,403,823	73.00
74.00	07400	RENAL DIALYSIS	266	266	253,830	0	406,251	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	7,559	7,559	253,010	0	521,478	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	4,632	4,632	3,249	0	871,679	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	13,657	13,657	2,285,845	0	3,589,729	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	675,376	675,376	45,660,327	-40,424,321	107,132,503	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	744	744	0	0	15,158	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	133,128	0	312,099	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	0	72,802	0	98,605	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,581,296	12,194,027	10,552,034		40,424,321	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.338780	18.035300	0.230061		0.375836	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			40,219		550,953	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000877		0.005122	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 2:17 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	224,775					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	690	592,157				8.00
9.00	00900	HOUSEKEEPING	2,455	0	221,630			9.00
10.00	01000	DIETARY	3,857	0	3,857	60,220		10.00
11.00	01100	CAFETERIA	2,440	0	2,440	0	44,945	11.00
13.00	01300	NURSING ADMINISTRATION	1,819	0	1,819	0	3,302	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,986	0	4,986	0	1,190	14.00
15.00	01500	PHARMACY	3,278	0	3,278	0	1,591	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	825	0	825	0	842	16.00
17.00	01700	SOCIAL SERVICE	607	0	607	0	758	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,185	144,108	37,185	47,604	9,128	30.00
31.00	03100	INTENSIVE CARE UNIT	11,486	87,125	11,486	4,618	2,260	31.00
31.01	03101	NEONATAL ICU	0	0	0	0	69	31.01
43.00	04300	NURSERY	109	0	109	0	401	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,550	139,376	23,550	0	3,231	50.00
51.00	05100	RECOVERY ROOM	2,300	15,700	2,300	0	1,853	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,204	0	15,204	0	907	52.00
53.00	05300	ANESTHESIOLOGY	368	0	368	0	105	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,549	39,029	22,549	0	2,371	54.00
54.01	05401	ULTRASOUND	692	3,053	692	0	372	54.01
56.00	05600	RADIOISOTOPE	1,134	0	1,134	0	347	56.00
57.00	05700	CT SCAN	1,141	0	1,141	0	847	57.00
58.00	05800	MRI	1,347	0	1,347	0	256	58.00
60.00	06000	LABORATORY	7,773	0	7,773	0	4,246	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	400	0	400	0	155	62.00
65.00	06500	RESPIRATORY THERAPY	1,149	0	1,149	0	1,163	65.00
66.00	06600	PHYSICAL THERAPY	20,038	0	20,038	0	1,917	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,416	0	5,416	0	625	67.00
68.00	06800	SPEECH PATHOLOGY	3,653	0	3,653	0	553	68.00
69.00	06900	ELECTROCARDIOLOGY	21,466	54,490	21,466	0	3,045	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	266	0	266	0	242	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	7,559	4,287	7,559	0	369	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	4,632	3,502	4,632	0	8	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	13,657	101,487	13,657	1,990	2,488	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	224,031	592,157	220,886	54,212	44,641	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	744	0	744	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	186	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	0	0	6,008	118	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	23,376,064	839,437	3,569,927	2,454,276	3,206,448	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	103.997615	1.417592	16.107598	40.755164	71.341595	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,699,787	43,622	157,378	238,017	156,731	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	38.704424	0.073666	0.710093	3.952458	3.487173	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 2:17 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (BILLABLE SUPPLIE)	PHARMACY (100% ALLOCAT)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	15,222,571					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,143,890				14.00
15.00	01500	PHARMACY	0	78,879	11,416,043			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,228	0	855,700,138		16.00
17.00	01700	SOCIAL SERVICE	0	2,598	0	0	20,402	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,848,662	688,511	0	63,780,749	16,646	30.00
31.00	03100	INTENSIVE CARE UNIT	2,056,176	228,878	0	10,946,518	2,240	31.00
31.01	03101	NEONATAL ICU	54,534	7,146	0	448,130	196	31.01
43.00	04300	NURSERY	320,877	41,667	0	2,612,912	1,320	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,047,014	1,522,606	0	136,122,851	0	50.00
51.00	05100	RECOVERY ROOM	1,327,835	155,990	0	23,484,228	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	726,122	94,290	0	5,912,841	0	52.00
53.00	05300	ANESTHESIOLOGY	288	153,561	0	32,522,939	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	444,271	131,777	0	38,773,900	0	54.00
54.01	05401	ULTRASOUND	4,089	14,371	0	9,777,929	0	54.01
56.00	05600	RADIOISOTOPE	9,791	229,824	0	13,123,103	0	56.00
57.00	05700	CT SCAN	38,884	79,155	0	43,515,545	0	57.00
58.00	05800	MRI	8,015	16,080	0	12,417,286	0	58.00
60.00	06000	LABORATORY	0	1,512,915	0	95,920,683	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	449,073	0	1,398,143	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	70,944	0	11,574,092	0	65.00
66.00	06600	PHYSICAL THERAPY	0	14,465	0	17,400,913	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,537	0	6,571,933	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,800	0	4,901,293	0	68.00
69.00	06900	ELECTROCARDIOLOGY	891,701	453,159	0	67,008,467	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,464,803	0	16,278,803	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,204,490	0	38,996,871	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	11,416,043	139,990,816	0	73.00
74.00	07400	RENAL DIALYSIS	190,622	69,815	0	3,552,872	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	18,264	0	3,757,505	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	867	77,750	0	7,750,837	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,218,866	340,536	0	47,157,979	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,188,614	14,135,112	11,416,043	855,700,138	20,402	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	33,957	8,778	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,857,857	2,662,262	3,640,513	2,072,296	1,352,521	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.384814	0.188227	0.318894	0.002422	66.293550	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	142,996	310,156	216,257	59,950	44,074	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.009394	0.021929	0.018943	0.000070	2.160278	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 2:17 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,127,111		27,127,111	0	27,127,111	30.00
31.00	03100	INTENSIVE CARE UNIT	7,449,079		7,449,079	0	7,449,079	31.00
31.01	03101	NEONATAL ICU	157,945		157,945	0	157,945	31.01
43.00	04300	NURSERY	949,849		949,849	0	949,849	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,739,946		12,739,946	0	12,739,946	50.00
51.00	05100	RECOVERY ROOM	4,089,687		4,089,687	0	4,089,687	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,096,870		4,096,870	0	4,096,870	52.00
53.00	05300	ANESTHESIOLOGY	468,124		468,124	0	468,124	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,183,760		8,183,760	0	8,183,760	54.00
54.01	05401	ULTRASOUND	917,422		917,422	0	917,422	54.01
56.00	05600	RADIOISOTOPE	1,316,552		1,316,552	0	1,316,552	56.00
57.00	05700	CT SCAN	1,646,048		1,646,048	0	1,646,048	57.00
58.00	05800	MRI	703,022		703,022	0	703,022	58.00
60.00	06000	LABORATORY	9,842,588		9,842,588	0	9,842,588	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,047,058		1,047,058	0	1,047,058	62.00
65.00	06500	RESPIRATORY THERAPY	2,116,447	0	2,116,447	0	2,116,447	65.00
66.00	06600	PHYSICAL THERAPY	6,279,147	0	6,279,147	0	6,279,147	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,875,341	0	1,875,341	0	1,875,341	67.00
68.00	06800	SPEECH PATHOLOGY	1,412,942	0	1,412,942	0	1,412,942	68.00
69.00	06900	ELECTROCARDIOLOGY	10,735,935		10,735,935	0	10,735,935	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,486,636		2,486,636	0	2,486,636	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,533,277		9,533,277	0	9,533,277	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,669,151		19,669,151	0	19,669,151	73.00
74.00	07400	RENAL DIALYSIS	703,248		703,248	0	703,248	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0		0	0	0	76.00
76.01	03610	SLEEP LAB	1,670,284		1,670,284	0	1,670,284	76.01
76.02	03020	ACUPUNCTURE	0		0	0	0	76.02
76.03	03040	WOUND CARE	1,794,891		1,794,891	0	1,794,891	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	8,013,788		8,013,788	0	8,013,788	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,264,328		2,264,328		2,264,328	92.00
200.00		Subtotal (see instructions)	149,290,476	0	149,290,476	0	149,290,476	200.00
201.00		Less Observation Beds	2,264,328		2,264,328		2,264,328	201.00
202.00		Total (see instructions)	147,026,148	0	147,026,148	0	147,026,148	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 2:17 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	59,726,432		59,726,432			30.00
31.00	03100	INTENSIVE CARE UNIT	10,946,518		10,946,518			31.00
31.01	03101	NEONATAL ICU	448,130		448,130			31.01
43.00	04300	NURSERY	2,612,912		2,612,912			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,726,184	104,396,667	136,122,851	0.093592	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,349,818	19,134,410	23,484,228	0.174146	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,929,755	983,086	5,912,841	0.692877	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	8,430,025	24,092,914	32,522,939	0.014394	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,418,555	28,355,345	38,773,900	0.211064	0.000000	54.00
54.01	05401	ULTRASOUND	1,741,916	8,036,013	9,777,929	0.093826	0.000000	54.01
56.00	05600	RADIOISOTOPE	1,098,866	12,024,237	13,123,103	0.100323	0.000000	56.00
57.00	05700	CT SCAN	12,244,251	31,271,294	43,515,545	0.037827	0.000000	57.00
58.00	05800	MRI	3,012,952	9,404,334	12,417,286	0.056616	0.000000	58.00
60.00	06000	LABORATORY	34,323,794	61,596,889	95,920,683	0.102612	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,173,209	224,934	1,398,143	0.748892	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	9,862,191	1,711,901	11,574,092	0.182861	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,018,943	12,381,970	17,400,913	0.360852	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,448,161	2,123,772	6,571,933	0.285356	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,158,289	2,743,004	4,901,293	0.288279	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	22,833,657	44,174,810	67,008,467	0.160218	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,159,173	10,119,630	16,278,803	0.152753	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,445,463	26,551,408	38,996,871	0.244463	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,032,026	106,958,790	139,990,816	0.140503	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,552,872	0	3,552,872	0.197938	0.000000	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	453,623	3,303,882	3,757,505	0.444519	0.000000	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.02
76.03	03040	WOUND CARE	44,508	7,706,329	7,750,837	0.231574	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	12,088,475	35,069,504	47,157,979	0.169935	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	949,763	3,104,554	4,054,317	0.558498	0.000000	92.00
200.00		Subtotal (see instructions)	300,230,461	555,469,677	855,700,138			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	300,230,461	555,469,677	855,700,138			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 2:17 pm

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		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
31.01	03101	NEONATAL ICU	
43.00	04300	NURSERY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.093592
51.00	05100	RECOVERY ROOM	0.174146
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.692877
53.00	05300	ANESTHESIOLOGY	0.014394
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.211064
54.01	05401	ULTRASOUND	0.093826
56.00	05600	RADIOISOTOPE	0.100323
57.00	05700	CT SCAN	0.037827
58.00	05800	MRI	0.056616
60.00	06000	LABORATORY	0.102612
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.748892
65.00	06500	RESPIRATORY THERAPY	0.182861
66.00	06600	PHYSICAL THERAPY	0.360852
67.00	06700	OCCUPATIONAL THERAPY	0.285356
68.00	06800	SPEECH PATHOLOGY	0.288279
69.00	06900	ELECTROCARDIOLOGY	0.160218
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.152753
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.244463
73.00	07300	DRUGS CHARGED TO PATIENTS	0.140503
74.00	07400	RENAL DIALYSIS	0.197938
76.00	03950	OTHER ANCILLARY-OTHER	0.000000
76.01	03610	SLEEP LAB	0.444519
76.02	03020	ACUPUNCTURE	0.000000
76.03	03040	WOUND CARE	0.231574
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	0.000000
91.00	09100	EMERGENCY	0.169935
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.558498
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 2:17 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,127,111		27,127,111	0	27,127,111	30.00
31.00	03100	INTENSIVE CARE UNIT	7,449,079		7,449,079	0	7,449,079	31.00
31.01	03101	NEONATAL ICU	157,945		157,945	0	157,945	31.01
43.00	04300	NURSERY	949,849		949,849	0	949,849	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,739,946		12,739,946	0	12,739,946	50.00
51.00	05100	RECOVERY ROOM	4,089,687		4,089,687	0	4,089,687	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,096,870		4,096,870	0	4,096,870	52.00
53.00	05300	ANESTHESIOLOGY	468,124		468,124	0	468,124	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,183,760		8,183,760	0	8,183,760	54.00
54.01	05401	ULTRASOUND	917,422		917,422	0	917,422	54.01
56.00	05600	RADIOISOTOPE	1,316,552		1,316,552	0	1,316,552	56.00
57.00	05700	CT SCAN	1,646,048		1,646,048	0	1,646,048	57.00
58.00	05800	MRI	703,022		703,022	0	703,022	58.00
60.00	06000	LABORATORY	9,842,588		9,842,588	0	9,842,588	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,047,058		1,047,058	0	1,047,058	62.00
65.00	06500	RESPIRATORY THERAPY	2,116,447	0	2,116,447	0	2,116,447	65.00
66.00	06600	PHYSICAL THERAPY	6,279,147	0	6,279,147	0	6,279,147	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,875,341	0	1,875,341	0	1,875,341	67.00
68.00	06800	SPEECH PATHOLOGY	1,412,942	0	1,412,942	0	1,412,942	68.00
69.00	06900	ELECTROCARDIOLOGY	10,735,935		10,735,935	0	10,735,935	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,486,636		2,486,636	0	2,486,636	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,533,277		9,533,277	0	9,533,277	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,669,151		19,669,151	0	19,669,151	73.00
74.00	07400	RENAL DIALYSIS	703,248		703,248	0	703,248	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0		0	0	0	76.00
76.01	03610	SLEEP LAB	1,670,284		1,670,284	0	1,670,284	76.01
76.02	03020	ACUPUNCTURE	0		0	0	0	76.02
76.03	03040	WOUND CARE	1,794,891		1,794,891	0	1,794,891	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	8,013,788		8,013,788	0	8,013,788	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,264,328		2,264,328		2,264,328	92.00
200.00		Subtotal (see instructions)	149,290,476	0	149,290,476	0	149,290,476	200.00
201.00		Less Observation Beds	2,264,328		2,264,328		2,264,328	201.00
202.00		Total (see instructions)	147,026,148	0	147,026,148	0	147,026,148	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 2:17 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	59,726,432		59,726,432			30.00
31.00	03100	INTENSIVE CARE UNIT	10,946,518		10,946,518			31.00
31.01	03101	NEONATAL ICU	448,130		448,130			31.01
43.00	04300	NURSERY	2,612,912		2,612,912			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,726,184	104,396,667	136,122,851	0.093592	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,349,818	19,134,410	23,484,228	0.174146	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,929,755	983,086	5,912,841	0.692877	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	8,430,025	24,092,914	32,522,939	0.014394	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,418,555	28,355,345	38,773,900	0.211064	0.000000	54.00
54.01	05401	ULTRASOUND	1,741,916	8,036,013	9,777,929	0.093826	0.000000	54.01
56.00	05600	RADIOISOTOPE	1,098,866	12,024,237	13,123,103	0.100323	0.000000	56.00
57.00	05700	CT SCAN	12,244,251	31,271,294	43,515,545	0.037827	0.000000	57.00
58.00	05800	MRI	3,012,952	9,404,334	12,417,286	0.056616	0.000000	58.00
60.00	06000	LABORATORY	34,323,794	61,596,889	95,920,683	0.102612	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,173,209	224,934	1,398,143	0.748892	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	9,862,191	1,711,901	11,574,092	0.182861	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,018,943	12,381,970	17,400,913	0.360852	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,448,161	2,123,772	6,571,933	0.285356	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,158,289	2,743,004	4,901,293	0.288279	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	22,833,657	44,174,810	67,008,467	0.160218	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,159,173	10,119,630	16,278,803	0.152753	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,445,463	26,551,408	38,996,871	0.244463	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,032,026	106,958,790	139,990,816	0.140503	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,552,872	0	3,552,872	0.197938	0.000000	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	453,623	3,303,882	3,757,505	0.444519	0.000000	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.02
76.03	03040	WOUND CARE	44,508	7,706,329	7,750,837	0.231574	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	12,088,475	35,069,504	47,157,979	0.169935	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	949,763	3,104,554	4,054,317	0.558498	0.000000	92.00
200.00		Subtotal (see instructions)	300,230,461	555,469,677	855,700,138			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	300,230,461	555,469,677	855,700,138			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 2:17 pm

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		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
31.01	03101	NEONATAL ICU	
43.00	04300	NURSERY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.093592
51.00	05100	RECOVERY ROOM	0.174146
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.692877
53.00	05300	ANESTHESIOLOGY	0.014394
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.211064
54.01	05401	ULTRASOUND	0.093826
56.00	05600	RADIOISOTOPE	0.100323
57.00	05700	CT SCAN	0.037827
58.00	05800	MRI	0.056616
60.00	06000	LABORATORY	0.102612
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.748892
65.00	06500	RESPIRATORY THERAPY	0.182861
66.00	06600	PHYSICAL THERAPY	0.360852
67.00	06700	OCCUPATIONAL THERAPY	0.285356
68.00	06800	SPEECH PATHOLOGY	0.288279
69.00	06900	ELECTROCARDIOLOGY	0.160218
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.152753
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.244463
73.00	07300	DRUGS CHARGED TO PATIENTS	0.140503
74.00	07400	RENAL DIALYSIS	0.197938
76.00	03950	OTHER ANCILLARY-OTHER	0.000000
76.01	03610	SLEEP LAB	0.444519
76.02	03020	ACUPUNCTURE	0.000000
76.03	03040	WOUND CARE	0.231574
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	0.000000
91.00	09100	EMERGENCY	0.169935
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.558498
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

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

Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/30/2024 2:17 pm

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		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,739,946	1,515,912	11,224,034	0	0	50.00
51.00	05100	RECOVERY ROOM	4,089,687	175,422	3,914,265	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,096,870	929,213	3,167,657	0	0	52.00
53.00	05300	ANESTHESIOLOGY	468,124	29,207	438,917	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,183,760	1,389,399	6,794,361	0	0	54.00
54.01	05401	ULTRASOUND	917,422	47,177	870,245	0	0	54.01
56.00	05600	RADIOISOTOPE	1,316,552	79,413	1,237,139	0	0	56.00
57.00	05700	CT SCAN	1,646,048	81,777	1,564,271	0	0	57.00
58.00	05800	MRI	703,022	84,740	618,282	0	0	58.00
60.00	06000	LABORATORY	9,842,588	551,525	9,291,063	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,047,058	37,872	1,009,186	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,116,447	82,856	2,033,591	0	0	65.00
66.00	06600	PHYSICAL THERAPY	6,279,147	1,221,456	5,057,691	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,875,341	331,320	1,544,021	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,412,942	224,580	1,188,362	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,735,935	1,350,690	9,385,245	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,486,636	41,346	2,445,290	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,533,277	169,571	9,363,706	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,669,151	284,516	19,384,635	0	0	73.00
74.00	07400	RENAL DIALYSIS	703,248	22,622	680,626	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,670,284	457,103	1,213,181	0	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	1,794,891	283,951	1,510,940	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	8,013,788	892,555	7,121,233	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,264,328	219,633	2,044,695	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	113,606,492	10,503,856	103,102,636	0	0	200.00
201.00		Less Observation Beds	2,264,328	219,633	2,044,695	0	0	201.00
202.00		Total (line 200 minus line 201)	111,342,164	10,284,223	101,057,941	0	0	202.00

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

Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/30/2024 2:17 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	12,739,946	136,122,851	0.093592		50.00
51.00	05100	RECOVERY ROOM	4,089,687	23,484,228	0.174146		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,096,870	5,912,841	0.692877		52.00
53.00	05300	ANESTHESIOLOGY	468,124	32,522,939	0.014394		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,183,760	38,773,900	0.211064		54.00
54.01	05401	ULTRASOUND	917,422	9,777,929	0.093826		54.01
56.00	05600	RADIOISOTOPE	1,316,552	13,123,103	0.100323		56.00
57.00	05700	CT SCAN	1,646,048	43,515,545	0.037827		57.00
58.00	05800	MRI	703,022	12,417,286	0.056616		58.00
60.00	06000	LABORATORY	9,842,588	95,920,683	0.102612		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,047,058	1,398,143	0.748892		62.00
65.00	06500	RESPIRATORY THERAPY	2,116,447	11,574,092	0.182861		65.00
66.00	06600	PHYSICAL THERAPY	6,279,147	17,400,913	0.360852		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,875,341	6,571,933	0.285356		67.00
68.00	06800	SPEECH PATHOLOGY	1,412,942	4,901,293	0.288279		68.00
69.00	06900	ELECTROCARDIOLOGY	10,735,935	67,008,467	0.160218		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,486,636	16,278,803	0.152753		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,533,277	38,996,871	0.244463		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,669,151	139,990,816	0.140503		73.00
74.00	07400	RENAL DIALYSIS	703,248	3,552,872	0.197938		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0.000000		76.00
76.01	03610	SLEEP LAB	1,670,284	3,757,505	0.444519		76.01
76.02	03020	ACUPUNCTURE	0	0	0.000000		76.02
76.03	03040	WOUND CARE	1,794,891	7,750,837	0.231574		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0.000000		90.00
91.00	09100	EMERGENCY	8,013,788	47,157,979	0.169935		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,264,328	4,054,317	0.558498		92.00
200.00		Subtotal (sum of lines 50 thru 199)	113,606,492	781,966,146			200.00
201.00		Less Observation Beds	2,264,328	0			201.00
202.00		Total (line 200 minus line 201)	111,342,164	781,966,146			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/30/2024 2:17 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,631,260	0	2,631,260	18,162	144.88	30.00
31.00	INTENSIVE CARE UNIT	768,113		768,113	2,240	342.91	31.00
31.01	NEONATAL ICU	1,849		1,849	196	9.43	31.01
43.00	NURSERY	17,716		17,716	1,320	13.42	43.00
200.00	Total (lines 30 through 199)	3,418,938		3,418,938	21,918		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	5,343	774,094	30.00
31.00	INTENSIVE CARE UNIT	704	241,409	31.00
31.01	NEONATAL ICU	0	0	31.01
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	6,047	1,015,503	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/30/2024 2:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,515,912	136,122,851	0.011136	9,087,900	101,203	50.00
51.00	05100	RECOVERY ROOM	175,422	23,484,228	0.007470	1,098,811	8,208	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	929,213	5,912,841	0.157152	37,305	5,863	52.00
53.00	05300	ANESTHESIOLOGY	29,207	32,522,939	0.000898	2,126,818	1,910	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,389,399	38,773,900	0.035833	885,701	31,737	54.00
54.01	05401	ULTRASOUND	47,177	9,777,929	0.004825	477,281	2,303	54.01
56.00	05600	RADIOISOTOPE	79,413	13,123,103	0.006051	317,529	1,921	56.00
57.00	05700	CT SCAN	81,777	43,515,545	0.001879	3,987,366	7,492	57.00
58.00	05800	MRI	84,740	12,417,286	0.006824	927,261	6,328	58.00
60.00	06000	LABORATORY	551,525	95,920,683	0.005750	10,456,295	60,124	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	37,872	1,398,143	0.027087	610,022	16,524	62.00
65.00	06500	RESPIRATORY THERAPY	82,856	11,574,092	0.007159	2,443,818	17,495	65.00
66.00	06600	PHYSICAL THERAPY	1,221,456	17,400,913	0.070195	1,851,395	129,959	66.00
67.00	06700	OCCUPATIONAL THERAPY	331,320	6,571,933	0.050414	1,631,135	82,232	67.00
68.00	06800	SPEECH PATHOLOGY	224,580	4,901,293	0.045821	831,813	38,115	68.00
69.00	06900	ELECTROCARDIOLOGY	1,350,690	67,008,467	0.020157	5,847,884	117,876	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	41,346	16,278,803	0.002540	2,137,207	5,429	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	169,571	38,996,871	0.004348	4,081,806	17,748	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	284,516	139,990,816	0.002032	11,395,181	23,155	73.00
74.00	07400	RENAL DIALYSIS	22,622	3,552,872	0.006367	1,524,874	9,709	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	457,103	3,757,505	0.121651	140,054	17,038	76.01
76.02	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.02
76.03	03040	WOUND CARE	283,951	7,750,837	0.036635	7,861	288	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	892,555	47,157,979	0.018927	3,774,537	71,441	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	219,633	4,054,317	0.054173	313,873	17,003	92.00
200.00		Total (lines 50 through 199)	10,503,856	781,966,146		65,993,727	791,101	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/30/2024 2:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	03101	NEONATAL ICU	0	0	0	0	0	31.01
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	18,162	0.00	5,343	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,240	0.00	704	31.00
31.01	03101	NEONATAL ICU		0	196	0.00	0	31.01
43.00	04300	NURSERY		0	1,320	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	21,918		6,047	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
31.01	03101	NEONATAL ICU	0	31.01
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/30/2024 2:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
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: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/30/2024 2:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	136,122,851	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	23,484,228	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,912,841	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	32,522,939	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	38,773,900	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	9,777,929	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	13,123,103	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	43,515,545	0.000000	57.00
58.00	05800	MRI	0	0	0	12,417,286	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	95,920,683	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,398,143	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,574,092	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	17,400,913	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,571,933	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,901,293	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	67,008,467	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	16,278,803	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	38,996,871	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	139,990,816	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,552,872	0.000000	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	3,757,505	0.000000	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.02
76.03	03040	WOUND CARE	0	0	0	7,750,837	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	47,157,979	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,054,317	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	781,966,146		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/30/2024 2:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	9,087,900	0	26,607,392	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,098,811	0	3,310,842	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	37,305	0	98,770	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,126,818	0	5,272,555	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	885,701	0	3,000,270	0	54.00
54.01	05401	ULTRASOUND	0.000000	477,281	0	911,529	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	317,529	0	4,238,186	0	56.00
57.00	05700	CT SCAN	0.000000	3,987,366	0	6,911,275	0	57.00
58.00	05800	MRI	0.000000	927,261	0	2,661,498	0	58.00
60.00	06000	LABORATORY	0.000000	10,456,295	0	5,707,396	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	610,022	0	103,631	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,443,818	0	796,231	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,851,395	0	19,043	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,631,135	0	15,907	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	831,813	0	21,223	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	5,847,884	0	13,311,003	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,137,207	0	1,762,378	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,081,806	0	7,761,258	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	11,395,181	0	37,617,964	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,524,874	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	140,054	0	594,329	0	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.02
76.03	03040	WOUND CARE	0.000000	7,861	0	799,766	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	3,774,537	0	5,038,301	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	313,873	0	521,870	0	92.00
200.00		Total (lines 50 through 199)		65,993,727	0	127,082,617	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/30/2024 2:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.093592	26,607,392	0	0	2,490,239	50.00
51.00	05100	RECOVERY ROOM	0.174146	3,310,842	0	0	576,570	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.692877	98,770	0	0	68,435	52.00
53.00	05300	ANESTHESIOLOGY	0.014394	5,272,555	0	0	75,893	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.211064	3,000,270	0	0	633,249	54.00
54.01	05401	ULTRASOUND	0.093826	911,529	0	0	85,525	54.01
56.00	05600	RADIOISOTOPE	0.100323	4,238,186	0	0	425,188	56.00
57.00	05700	CT SCAN	0.037827	6,911,275	0	0	261,433	57.00
58.00	05800	MRI	0.056616	2,661,498	0	0	150,683	58.00
60.00	06000	LABORATORY	0.102612	5,707,396	0	0	585,647	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.748892	103,631	0	0	77,608	62.00
65.00	06500	RESPIRATORY THERAPY	0.182861	796,231	0	0	145,600	65.00
66.00	06600	PHYSICAL THERAPY	0.360852	19,043	0	0	6,872	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.285356	15,907	0	0	4,539	67.00
68.00	06800	SPEECH PATHOLOGY	0.288279	21,223	0	0	6,118	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160218	13,311,003	0	0	2,132,662	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.152753	1,762,378	0	0	269,209	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.244463	7,761,258	0	0	1,897,340	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.140503	37,617,964	0	8,497	5,285,437	73.00
74.00	07400	RENAL DIALYSIS	0.197938	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.444519	594,329	0	0	264,191	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.02
76.03	03040	WOUND CARE	0.231574	799,766	0	0	185,205	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.169935	5,038,301	0	0	856,184	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.558498	521,870	0	0	291,463	92.00
200.00		Subtotal (see instructions)		127,082,617	0	8,497	16,775,290	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		127,082,617	0	8,497	16,775,290	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/30/2024 2:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,194		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.02	03020	ACUPUNCTURE	0	0		76.02
76.03	03040	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	1,194		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,194		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/30/2024 2:17 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,631,260	0	2,631,260	18,162	144.88	30.00
31.00	INTENSIVE CARE UNIT	768,113		768,113	2,240	342.91	31.00
31.01	NEONATAL ICU	1,849		1,849	196	9.43	31.01
43.00	NURSERY	17,716		17,716	1,320	13.42	43.00
200.00	Total (lines 30 through 199)	3,418,938		3,418,938	21,918		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	519	75,193	30.00
31.00	INTENSIVE CARE UNIT	31	10,630	31.00
31.01	NEONATAL ICU	0	0	31.01
43.00	NURSERY	1,229	16,493	43.00
200.00	Total (lines 30 through 199)	1,779	102,316	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/30/2024 2:17 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,515,912	136,122,851	0.011136	682,505	7,600	50.00
51.00	05100	RECOVERY ROOM	175,422	23,484,228	0.007470	120,303	899	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	929,213	5,912,841	0.157152	152,451	23,958	52.00
53.00	05300	ANESTHESIOLOGY	29,207	32,522,939	0.000898	174,482	157	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,389,399	38,773,900	0.035833	70,907	2,541	54.00
54.01	05401	ULTRASOUND	47,177	9,777,929	0.004825	47,020	227	54.01
56.00	05600	RADIOISOTOPE	79,413	13,123,103	0.006051	21,033	127	56.00
57.00	05700	CT SCAN	81,777	43,515,545	0.001879	278,395	523	57.00
58.00	05800	MRI	84,740	12,417,286	0.006824	70,667	482	58.00
60.00	06000	LABORATORY	551,525	95,920,683	0.005750	1,168,489	6,719	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	37,872	1,398,143	0.027087	74,871	2,028	62.00
65.00	06500	RESPIRATORY THERAPY	82,856	11,574,092	0.007159	258,016	1,847	65.00
66.00	06600	PHYSICAL THERAPY	1,221,456	17,400,913	0.070195	128,033	8,987	66.00
67.00	06700	OCCUPATIONAL THERAPY	331,320	6,571,933	0.050414	113,986	5,746	67.00
68.00	06800	SPEECH PATHOLOGY	224,580	4,901,293	0.045821	52,359	2,399	68.00
69.00	06900	ELECTROCARDIOLOGY	1,350,690	67,008,467	0.020157	303,313	6,114	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	41,346	16,278,803	0.002540	146,381	372	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	169,571	38,996,871	0.004348	66,822	291	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	284,516	139,990,816	0.002032	1,323,222	2,689	73.00
74.00	07400	RENAL DIALYSIS	22,622	3,552,872	0.006367	62,584	398	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	457,103	3,757,505	0.121651	24,026	2,923	76.01
76.02	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.02
76.03	03040	WOUND CARE	283,951	7,750,837	0.036635	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	892,555	47,157,979	0.018927	380,728	7,206	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	219,633	4,054,317	0.054173	8,656	469	92.00
200.00		Total (lines 50 through 199)	10,503,856	781,966,146		5,729,249	84,702	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/30/2024 2:17 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	03101	NEONATAL ICU	0	0	0	0	0	31.01
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	18,162	0.00	519	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,240	0.00	31	31.00
31.01	03101	NEONATAL ICU		0	196	0.00	0	31.01
43.00	04300	NURSERY		0	1,320	0.00	1,229	43.00
200.00		Total (lines 30 through 199)		0	21,918		1,779	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
31.01	03101	NEONATAL ICU	0	31.01
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/30/2024 2:17 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
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: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/30/2024 2:17 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	136,122,851	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	23,484,228	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,912,841	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	32,522,939	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	38,773,900	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	9,777,929	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	13,123,103	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	43,515,545	0.000000	57.00
58.00	05800	MRI	0	0	0	12,417,286	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	95,920,683	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,398,143	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,574,092	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	17,400,913	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,571,933	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,901,293	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	67,008,467	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	16,278,803	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	38,996,871	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	139,990,816	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,552,872	0.000000	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	3,757,505	0.000000	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.02
76.03	03040	WOUND CARE	0	0	0	7,750,837	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	47,157,979	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,054,317	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	781,966,146		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/30/2024 2:17 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	682,505	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	120,303	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	152,451	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	174,482	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	70,907	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	47,020	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	21,033	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	278,395	0	0	0	57.00
58.00	05800	MRI	0.000000	70,667	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,168,489	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	74,871	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	258,016	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	128,033	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	113,986	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	52,359	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	303,313	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	146,381	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	66,822	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,323,222	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	62,584	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	24,026	0	0	0	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.02
76.03	03040	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	380,728	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	8,656	0	0	0	92.00
200.00		Total (lines 50 through 199)		5,729,249	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/30/2024 2:17 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.093592	0	0	1,078,302	0	50.00
51.00	05100	RECOVERY ROOM	0.174146	0	0	201,250	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.692877	0	0	19,836	0	52.00
53.00	05300	ANESTHESIOLOGY	0.014394	0	0	190,252	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.211064	0	0	210,205	0	54.00
54.01	05401	ULTRASOUND	0.093826	0	0	146,360	0	54.01
56.00	05600	RADIOISOTOPE	0.100323	0	0	102,436	0	56.00
57.00	05700	CT SCAN	0.037827	0	0	752,369	0	57.00
58.00	05800	MRI	0.056616	0	0	152,179	0	58.00
60.00	06000	LABORATORY	0.102612	0	0	1,180,507	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.748892	0	0	12,988	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.182861	0	0	17,830	0	65.00
66.00	06600	PHYSICAL THERAPY	0.360852	0	0	169,047	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.285356	0	0	164,612	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.288279	0	0	163,188	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160218	0	0	407,014	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.152753	0	0	100,721	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.244463	0	0	213,858	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.140503	0	0	1,691,263	0	73.00
74.00	07400	RENAL DIALYSIS	0.197938	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.444519	0	0	30,506	0	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.02
76.03	03040	WOUND CARE	0.231574	0	0	50,545	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.169935	0	0	1,361,723	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.558498	0	0	62,201	0	92.00
200.00		Subtotal (see instructions)		0	0	8,479,192	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	8,479,192	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/30/2024 2:17 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	100,920		50.00
51.00	05100	RECOVERY ROOM	0	35,047		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	13,744		52.00
53.00	05300	ANESTHESIOLOGY	0	2,738		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	44,367		54.00
54.01	05401	ULTRASOUND	0	13,732		54.01
56.00	05600	RADIOISOTOPE	0	10,277		56.00
57.00	05700	CT SCAN	0	28,460		57.00
58.00	05800	MRI	0	8,616		58.00
60.00	06000	LABORATORY	0	121,134		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	9,727		62.00
65.00	06500	RESPIRATORY THERAPY	0	3,260		65.00
66.00	06600	PHYSICAL THERAPY	0	61,001		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	46,973		67.00
68.00	06800	SPEECH PATHOLOGY	0	47,044		68.00
69.00	06900	ELECTROCARDIOLOGY	0	65,211		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,385		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	52,280		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	237,628		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0		76.00
76.01	03610	SLEEP LAB	0	13,560		76.01
76.02	03020	ACUPUNCTURE	0	0		76.02
76.03	03040	WOUND CARE	0	11,705		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	231,404		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	34,739		92.00
200.00		Subtotal (see instructions)	0	1,208,952		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,208,952		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 2:17 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	18,178	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	18,162	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)	16,646	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	16	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	5,343	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)	5	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	27,127,111	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)	27,127,111	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	27,127,111	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,493.62	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,980,412	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	7,980,412	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 2:17 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,449,079	2,240	3,325.48	704	2,341,138	43.00
43.01	NEONATAL ICU	157,945	196	805.84	0	0	43.01
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)	9,960,203	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)	20,281,753	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,015,503	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	791,101	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,806,604	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	18,475,149	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)	1,516	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,493.62	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0006	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/30/2024 2:17 pm
	Title XVIII	Hospital	PPS

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,264,328	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,631,260	27,127,111	0.096997	2,264,328	219,633	90.00
91.00	Nursing Program cost	0	27,127,111	0.000000	2,264,328	0	91.00
92.00	Allied health cost	0	27,127,111	0.000000	2,264,328	0	92.00
93.00	All other Medical Education	0	27,127,111	0.000000	2,264,328	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 2:17 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	18,178	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	18,162	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)	16,646	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	16	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)	519	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)	1,320	15.00
16.00	Nursery days (title V or XIX only)	1,229	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	27,127,111	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)	27,127,111	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	27,127,111	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,493.62	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	775,189	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)	775,189	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 2:17 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	949,849	1,320	719.58	1,229	884,364	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,449,079	2,240	3,325.48	31	103,090	43.00
43.01	NEONATAL ICU	157,945	196	805.84	0	0	43.01
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)	911,772	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)	2,674,415	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)	102,316	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	84,702	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	187,018	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,487,397	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)	1,516	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,493.62	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0006	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/30/2024 2:17 pm
	Title XIX	Hospital	PPS

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,264,328	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,631,260	27,127,111	0.096997	2,264,328	219,633	90.00
91.00	Nursing Program cost	0	27,127,111	0.000000	2,264,328	0	91.00
92.00	Allied health cost	0	27,127,111	0.000000	2,264,328	0	92.00
93.00	All other Medical Education	0	27,127,111	0.000000	2,264,328	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/30/2024 2:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		18,291,438		30.00
31.00	03100	INTENSIVE CARE UNIT		3,394,331		31.00
31.01	03101	NEONATAL ICU		0		31.01
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.093592	9,087,900	850,555	50.00
51.00	05100	RECOVERY ROOM	0.174146	1,098,811	191,354	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.692877	37,305	25,848	52.00
53.00	05300	ANESTHESIOLOGY	0.014394	2,126,818	30,613	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.211064	885,701	186,940	54.00
54.01	05401	ULTRASOUND	0.093826	477,281	44,781	54.01
56.00	05600	RADIOISOTOPE	0.100323	317,529	31,855	56.00
57.00	05700	CT SCAN	0.037827	3,987,366	150,830	57.00
58.00	05800	MRI	0.056616	927,261	52,498	58.00
60.00	06000	LABORATORY	0.102612	10,456,295	1,072,941	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.748892	610,022	456,841	62.00
65.00	06500	RESPIRATORY THERAPY	0.182861	2,443,818	446,879	65.00
66.00	06600	PHYSICAL THERAPY	0.360852	1,851,395	668,080	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.285356	1,631,135	465,454	67.00
68.00	06800	SPEECH PATHOLOGY	0.288279	831,813	239,794	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160218	5,847,884	936,936	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.152753	2,137,207	326,465	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.244463	4,081,806	997,851	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.140503	11,395,181	1,601,057	73.00
74.00	07400	RENAL DIALYSIS	0.197938	1,524,874	301,831	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.444519	140,054	62,257	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	76.02
76.03	03040	WOUND CARE	0.231574	7,861	1,820	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.169935	3,774,537	641,426	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.558498	313,873	175,297	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		65,993,727	9,960,203	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)		65,993,727		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0006 | Component CCN: 15-U006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/30/2024 2:17 pm

Title XVIII | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
31.01	03101	NEONATAL ICU				31.01
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.093592	0	0	50.00
51.00	05100	RECOVERY ROOM	0.174146	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.692877	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.014394	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.211064	0	0	54.00
54.01	05401	ULTRASOUND	0.093826	0	0	54.01
56.00	05600	RADIOISOTOPE	0.100323	0	0	56.00
57.00	05700	CT SCAN	0.037827	0	0	57.00
58.00	05800	MRI	0.056616	0	0	58.00
60.00	06000	LABORATORY	0.102612	594	61	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.748892	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.182861	1,496	274	65.00
66.00	06600	PHYSICAL THERAPY	0.360852	2,016	727	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.285356	2,519	719	67.00
68.00	06800	SPEECH PATHOLOGY	0.288279	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160218	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.152753	1,050	160	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.244463	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.140503	4,399	618	73.00
74.00	07400	RENAL DIALYSIS	0.197938	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.444519	0	0	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	76.02
76.03	03040	WOUND CARE	0.231574	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.169935	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.558498	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		12,074	2,559	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)		12,074		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/30/2024 2:17 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,813,289		30.00
31.00	03100	INTENSIVE CARE UNIT		343,229		31.00
31.01	03101	NEONATAL ICU		0		31.01
43.00	04300	NURSERY		207,700		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.093592	682,505	63,877	50.00
51.00	05100	RECOVERY ROOM	0.174146	120,303	20,950	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.692877	152,451	105,630	52.00
53.00	05300	ANESTHESIOLOGY	0.014394	174,482	2,511	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.211064	70,907	14,966	54.00
54.01	05401	ULTRASOUND	0.093826	47,020	4,412	54.01
56.00	05600	RADIOISOTOPE	0.100323	21,033	2,110	56.00
57.00	05700	CT SCAN	0.037827	278,395	10,531	57.00
58.00	05800	MRI	0.056616	70,667	4,001	58.00
60.00	06000	LABORATORY	0.102612	1,168,489	119,901	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.748892	74,871	56,070	62.00
65.00	06500	RESPIRATORY THERAPY	0.182861	258,016	47,181	65.00
66.00	06600	PHYSICAL THERAPY	0.360852	128,033	46,201	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.285356	113,986	32,527	67.00
68.00	06800	SPEECH PATHOLOGY	0.288279	52,359	15,094	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160218	303,313	48,596	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.152753	146,381	22,360	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.244463	66,822	16,336	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.140503	1,323,222	185,917	73.00
74.00	07400	RENAL DIALYSIS	0.197938	62,584	12,388	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.444519	24,026	10,680	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	76.02
76.03	03040	WOUND CARE	0.231574	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.169935	380,728	64,699	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.558498	8,656	4,834	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,729,249	911,772	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)		5,729,249		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0006 | Component CCN: 15-U006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/30/2024 2:17 pm

Title XIX | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
31.01	03101	NEONATAL ICU				31.01
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.093592	0	0	50.00
51.00	05100	RECOVERY ROOM	0.174146	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.692877	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.014394	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.211064	0	0	54.00
54.01	05401	ULTRASOUND	0.093826	0	0	54.01
56.00	05600	RADIOISOTOPE	0.100323	0	0	56.00
57.00	05700	CT SCAN	0.037827	0	0	57.00
58.00	05800	MRI	0.056616	0	0	58.00
60.00	06000	LABORATORY	0.102612	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.748892	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.182861	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.360852	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.285356	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.288279	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160218	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.152753	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.244463	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.140503	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.197938	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.444519	0	0	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	76.02
76.03	03040	WOUND CARE	0.231574	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.169935	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.558498	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/30/2024 2:17 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	8,978,760	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,862,937	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	95,516	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	92,279	2.04
3.00	Managed Care Simulated Payments	10,253,585	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	79.79	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.89	30.00
31.00	Percentage of Medicaid patient days (see instructions)	26.16	31.00
32.00	Sum of lines 30 and 31	30.05	32.00
33.00	Allowable disproportionate share percentage (see instructions)	14.01	33.00
34.00	Disproportionate share adjustment (see instructions)	449,780	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/30/2024 2:17 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	685,817	571,443	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	512,953	143,641	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	656,594		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	14,135,866		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	14,135,866	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,013,156	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	53,668	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	15,202,690	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	15,202,690	61.00
62.00	Deductibles billed to program beneficiaries	1,493,652	62.00
63.00	Coinsurance billed to program beneficiaries	20,712	63.00
64.00	Allowable bad debts (see instructions)	120,804	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	78,523	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	20,684	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	13,766,849	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)	0	70.75
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-4,908	70.93
70.94	HRR adjustment amount (see instructions)	-85,774	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/30/2024 2:17 pm
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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		13,676,167	71.00
71.01	Sequestration adjustment (see instructions)		273,523	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		13,186,615	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		216,029	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,565,757	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part B Date/Time Prepared: 5/30/2024 2:17 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,194	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	16,775,290	2.00
3.00	OPPS or REH payments	14,510,236	3.00
4.00	Outlier payment (see instructions)	46,621	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)	1,194	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	8,497	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)	8,497	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	8,497	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	7,303	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)	1,194	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)	14,556,857	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	13,635	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,528,885	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)	12,015,531	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	12,015,531	30.00
31.00	Primary payer payments	61	31.00
32.00	Subtotal (line 30 minus line 31)	12,015,470	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	164,222	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	106,744	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	98,741	36.00
37.00	Subtotal (see instructions)	12,122,214	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	12,122,214	40.00
40.01	Sequestration adjustment (see instructions)	242,444	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	11,926,971	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-47,201	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 2:17 pm
	Title XVIII	Hospital	PPS

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2024 2:17 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		13,186,615		11,926,971	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)		13,186,615		11,926,971	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		216,029		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		47,201	6.02
7.00	Total Medicare program liability (see instructions)		13,402,644		11,879,770	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0006 | Component CCN: 15-U006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2024 2:17 pm

Title XVIII | Swing Beds - SNF | 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		4,034		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)		4,034		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,034		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0006	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/30/2024 2:17 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-0006 | Component CCN: 15-U006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/30/2024 2:17 pm

Title XVIII | Swing Beds - SNF | PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	4,116	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	5	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	4,116	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	4,116	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	4,116	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	4,116	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	4,116	0	19.00
19.01	Sequestration adjustment (see instructions)	82	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	4,034	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	0	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-0006 | Component CCN: 15-U006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/30/2024 2:17 pm

Title XIX | Swing Beds - SNF | PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2024 2:17 pm
	Title XIX	Hospital	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		1,208,952	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	1,208,952	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	1,208,952	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	1,987,290		8.00
9.00	Ancillary service charges	5,729,249	8,479,192	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	7,716,539	8,479,192	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	7,716,539	8,479,192	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	7,716,539	7,270,240	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	1,208,952	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	1,208,952	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	1,208,952	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	1,208,952	36.00
37.00	REMOVE SETTLEMENT	0	-1,208,862	37.00
38.00	Subtotal (line 36 ± line 37)	0	90	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	90	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	90	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0006	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/30/2024 2:17 pm
	Title XVIII		PPS

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/30/2024 2:17 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-22,473	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	40,509,102	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,844,591	0	0	0	6.00
7.00	Inventory	3,895,214	0	0	0	7.00
8.00	Prepaid expenses	2,739,700	0	0	0	8.00
9.00	Other current assets	317,689	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)	38,594,641	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,977,324	0	0	0	12.00
13.00	Land improvements	2,268,078	0	0	0	13.00
14.00	Accumulated depreciation	-1,098,951	0	0	0	14.00
15.00	Buildings	134,140,478	0	0	0	15.00
16.00	Accumulated depreciation	-24,770,220	0	0	0	16.00
17.00	Leasehold improvements	3,319,803	0	0	0	17.00
18.00	Accumulated depreciation	-166,820	0	0	0	18.00
19.00	Fixed equipment	2,227,556	0	0	0	19.00
20.00	Accumulated depreciation	-971,135	0	0	0	20.00
21.00	Automobiles and trucks	101,790	0	0	0	21.00
22.00	Accumulated depreciation	-101,790	0	0	0	22.00
23.00	Major movable equipment	28,903,885	0	0	0	23.00
24.00	Accumulated depreciation	-16,948,537	0	0	0	24.00
25.00	Minor equipment depreciable	7,947,609	0	0	0	25.00
26.00	Accumulated depreciation	-4,236,126	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	19,972,210	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	153,565,154	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	6,685,484	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,685,484	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	198,845,279	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	8,337,863	0	0	0	37.00
38.00	Salaries, wages, and fees payable	6,905,731	0	0	0	38.00
39.00	Payroll taxes payable	445,296	0	0	0	39.00
40.00	Notes and loans payable (short term)	33,333	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	27,320,014	0	0	0	43.00
44.00	Other current liabilities	1,490,164	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	44,532,401	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	30,558	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	20,463,117	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	20,493,675	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	65,026,076	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	133,819,203				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	133,819,203	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	198,845,279	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/30/2024 2:17 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		106,495,091		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		27,324,112				2.00
3.00	Total (sum of line 1 and line 2)		133,819,203		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)		133,819,203		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)		133,819,203		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0006 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/30/2024 2:17 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	62,339,344		62,339,344	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	62,339,344		62,339,344	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	10,946,518		10,946,518	11.00
11.01	NEONATAL ICU	448,130		448,130	11.01
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)	11,394,648		11,394,648	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	73,733,992		73,733,992	17.00
18.00	Ancillary services	213,390,770	517,363,080	730,753,850	18.00
19.00	Outpatient services	13,038,238	38,174,058	51,212,296	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	IP CONTRACTED HOSPICE	10,662	0	10,662	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	300,173,662	555,537,138	855,710,800	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		154,569,488		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)		154,569,488		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0006	Period: From 01/01/2023 To 12/31/2023	Worksheet G-3 Date/Time Prepared: 5/30/2024 2:17 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	855,710,800	1.00
2.00	Less contractual allowances and discounts on patients' accounts	675,534,825	2.00
3.00	Net patient revenues (line 1 minus line 2)	180,175,975	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	154,569,488	4.00
5.00	Net income from service to patients (line 3 minus line 4)	25,606,487	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	1,717,625	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	1,717,625	25.00
26.00	Total (line 5 plus line 25)	27,324,112	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)	27,324,112	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0006	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/30/2024 2:17 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	974,063	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	39,093	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	53.82	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	1,013,156	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00