

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: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/10/2024 1:04 pm
--	-----------------------	---------------------------------------	---

**PART I - COST REPORT STATUS**

Provider use only

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

Contractor use only

5.  Cost Report Status  
 (1) As Submitted  
 (2) Settled without Audit  
 (3) Settled with Audit  
 (4) Reopened  
 (5) Amended

6. Date Received:  
 7. Contractor No.  
 8.  Initial Report for this Provider CCN  
 9.  Final Report for this Provider CCN

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

Date: 5/10/2024 Time: 1:04 pm

**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 PAM REHAB HOSP OF GREATER INDIANA ( 15-3046 ) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	<b>Karick Stober</b>	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name		Karick Stober	2
3	Signatory Title		CFO	3
4	Date		(Dated when report is electronic)	4

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00	HOSPITAL	0	-125,229	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	2.00
3.00	SUBPROVIDER - IRF	0	0	0	0	3.00
5.00	SWING BED - SNF	0	0	0	0	5.00
6.00	SWING BED - NF	0	0	0	0	6.00
200.00	TOTAL	0	-125,229	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 15-3046		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/10/2024 1:04 pm			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 2101 BROADWAY STREET			PO Box:							1.00
2.00	City: CLARKSVILLE			State: IN		Zip Code: 47129		County:			2.00
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
		V		XVIII	XIX						
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		PAM REHAB HOSP OF GREATER INDIANA	153046	31140	5	04/16/2020	N	P	P	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2023	12/31/2023		20.00	
21.00	Type of Control (see instructions)						4			21.00	
							1.00	2.00	3.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00	
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01	
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.									22.04	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						2			23.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-3046			Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/10/2024 1:04 pm			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00	
						Urban/Rural S		Date of Geogr		
						1.00		2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00		
						Beginning:		Ending:		
						1.00		2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					0		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		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		40.00		
						V	XVII	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		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		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		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N		N		48.00
Teaching Hospitals										
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N				56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.									57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.									58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-3046		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/10/2024 1:04 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	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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: 15-3046		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/10/2024 1:04 pm	
			Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 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 Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))
			1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 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 Nonprovi der Si te	Unweighted FTEs in Hospi tal	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: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/10/2024 1:04 pm		
			1.00			
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?				68.00	
			1.00	2.00	3.00	
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N N 0	76.00
			1.00			
<b>Long Term Care Hospital PPS</b>						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N	81.00
<b>TEFRA Providers</b>						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					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)		N	0		
		Column 2: Enter the number of approved permanent adjustments.				
			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	
			V	XIX		
			1.00	2.00		
<b>Title V and XIX Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.				N	N
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.				N	N
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N
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
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.				N	N
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.				N	N
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/10/2024 1:04 pm	
		V 1.00	XIX 2.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06	
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				109.00
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00
				1.00	2.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.		N		111.00
				1.00	2.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
<b>Miscellaneous Cost Reporting Information</b>					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/10/2024 1:04 pm
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	80,455	0	0
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N	118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N	121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.		N	123.00
<b>Certified Transplant Center Information</b>				
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N	125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
<b>All Providers</b>				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	H09790
		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: PAM CUBED, LLC	Contractor's Name: NOVITAS SOLUTIONS		Contractor's Number: 04011
142.00	Street: 1828 GOODHOPE DR	PO Box:		
143.00	City: ENOLA	State: PA	Zip Code: 17025	
			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: 15-3046		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/10/2024 1:04 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	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	N	157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00	
161.00	CMHC		N	N	N	N	161.00	
1.00								
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
1.00								
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
		Beginning	Ending					
		1.00	2.00					
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00
		1.00	2.00					
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-3046		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part II Date/Time Prepared: 5/10/2024 1:04 pm	
		Y/N	Date				
		1.00	2.00				
<b>PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE</b>							
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
<b>Financial Data and Reports</b>							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
<b>Approved Educational Activities</b>							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					2.00
<b>Bad Debts</b>							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.					N	14.00
<b>Bed Complement</b>							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
<b>PS&amp;R Data</b>							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/16/2024	Y	04/16/2024		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-3046

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
5/10/2024 1:04 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		21.00
					1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>						
<b>Capital Related Cost</b>						
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				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
<b>Interest Expense</b>						
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				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
<b>Purchased Services</b>						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				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
<b>Provider-Based Physicians</b>						
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				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	
<b>Home Office Costs</b>						
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.				N	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
<b>Cost Report Preparer Contact Information</b>						
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID			MULLER	41.00
42.00	Enter the employer/company name of the cost report preparer.	POST ACUTE MEDICAL LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	210-592-5381			DMULLER@PAMHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-3046

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
5/10/2024 1:04 pm

		3.00	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VP OF REIMBURSEMENT	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: 15-3046

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/10/2024 1:04 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P		
	Line No.				Visits	Trips	
	1.00	2.00	3.00	4.00	5.00		
<b>PART I - STATISTICAL DATA</b>							
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	42	15,330	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)		42	15,330	0.00	0	7.00	
8.00 INTENSIVE CARE UNIT						8.00	
9.00 CORONARY CARE UNIT						9.00	
10.00 BURN INTENSIVE CARE UNIT						10.00	
11.00 SURGICAL INTENSIVE CARE UNIT						11.00	
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00	
13.00 NURSERY						13.00	
14.00 Total (see instructions)		42	15,330	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)		42				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: 15-3046

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/10/2024 1:04 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
<b>PART I - STATISTICAL DATA</b>						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	11,218	0	14,282		1.00
2.00	HMO and other (see instructions)	1,533	0			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	11,218	0	14,282		7.00
8.00	INTENSIVE CARE UNIT					8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY					13.00
14.00	Total (see instructions)	11,218	0	14,282	0.00	144.32
15.00	CAH visits	0	0	0		15.00
15.10	REH hours and visits	0	0	0		15.10
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	144.32
28.00	Observation Bed Days		0	0		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	0	0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0		34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-3046

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/10/2024 1:04 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
<b>PART I - STATISTICAL DATA</b>							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,074	0	1,360	1.00
2.00	HMO and other (see instructions)			153	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
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	1,074	0	1,360	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-3046

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

Worksheet A  
Date/Time Prepared:  
5/10/2024 1:04 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	3,160,349	3,160,349	1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	303,260	303,260	2.00	
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	99,170	880,551	979,721	979,721	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	834,852	6,093,279	6,928,131	-3,279,681	3,648,450	5.00
7.00	00700	OPERATION OF PLANT	211,910	528,653	740,563	-275	740,288	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	209,706	209,706	0	209,706	8.00
9.00	00900	HOUSEKEEPING	374,082	67,911	441,993	0	441,993	9.00
10.00	01000	DIETARY	446,371	316,484	762,855	-508	762,347	10.00
14.00	01400	CENTRAL SERVICES & SUPPLY	86,276	474,053	560,329	-386,778	173,551	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	184,487	60,372	244,859	-206	244,653	16.00
17.00	01700	SOCIAL SERVICE	1,328,537	186,068	1,514,605	-672,082	842,523	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	4,198,717	1,089,630	5,288,347	79,597	5,367,944	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,422	237,369	240,791	-65,898	174,893	54.00
60.00	06000	LABORATORY	190	50,450	50,640	0	50,640	60.00
65.00	06500	RESPIRATORY THERAPY	418,101	92,232	510,333	-52,018	458,315	65.00
66.00	06600	PHYSICAL THERAPY	1,360,470	134,049	1,494,519	-447	1,494,072	66.00
67.00	06700	OCCUPATIONAL THERAPY	924,702	80,657	1,005,359	0	1,005,359	67.00
68.00	06800	SPEECH PATHOLOGY	256,533	23,987	280,520	0	280,520	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	295,011	295,011	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	915,686	915,686	-52,406	863,280	73.00
74.00	07400	RENAL DIALYSIS	182,001	51,808	233,809	0	233,809	74.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,909,821	11,492,945	22,402,766	-672,082	21,730,684	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	MARKETING	177,712	71,474	249,186	672,082	921,268	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	11,087,533	11,564,419	22,651,952	0	22,651,952	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-3046

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

Worksheet A  
Date/Time Prepared:  
5/10/2024 1:04 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	76,874	3,237,223	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	303,260	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	979,721	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,818	3,675,268	5.00
7.00	00700	OPERATION OF PLANT	-20,504	719,784	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	209,706	8.00
9.00	00900	HOUSEKEEPING	0	441,993	9.00
10.00	01000	DIETARY	-12,322	750,025	10.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	173,551	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3	244,650	16.00
17.00	01700	SOCIAL SERVICE	0	842,523	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-406,638	4,961,306	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00	05400	RADIOLOGY-DIAGNOSTIC	-80,542	94,351	54.00
60.00	06000	LABORATORY	0	50,640	60.00
65.00	06500	RESPIRATORY THERAPY	0	458,315	65.00
66.00	06600	PHYSICAL THERAPY	0	1,494,072	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,005,359	67.00
68.00	06800	SPEECH PATHOLOGY	0	280,520	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	295,011	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	863,280	73.00
74.00	07400	RENAL DIALYSIS	0	233,809	74.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-416,317	21,314,367	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	MARKETING	-18,609	902,659	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-434,926	22,217,026	200.00

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
<b>A - FACILITY LEASE &amp; STORAGE EXPENSE</b>						
1.00	CAP REL COSTS-BLDG & FIXT		1.00	0	2,750,566	1.00
	TOTALS			0	2,750,566	
<b>B - EQUIPMENT LEASE EXPENSE</b>						
1.00	CAP REL COSTS-MVBLE EQUIP		2.00	0	218,062	1.00
2.00			0.00	0	0	2.00
3.00			0.00	0	0	3.00
4.00			0.00	0	0	4.00
5.00			0.00	0	0	5.00
6.00			0.00	0	0	6.00
7.00			0.00	0	0	7.00
8.00			0.00	0	0	8.00
9.00			0.00	0	0	9.00
	TOTALS			0	218,062	
<b>C - DEPRECIATION EXPENSE</b>						
1.00	CAP REL COSTS-BLDG & FIXT		1.00		10,905	1.00
2.00	CAP REL COSTS-MVBLE EQUIP		2.00		85,198	2.00
	TOTALS			0	96,103	
<b>D - CAPITAL INSURANCE &amp; PROPERTY TAX</b>						
1.00	CAP REL COSTS-BLDG & FIXT		1.00	0	21,572	1.00
2.00	CAP REL COSTS-BLDG & FIXT		1.00	0	366,000	2.00
	TOTALS			0	387,572	
<b>E - EXT CASE MANAGEMENT &amp; MARKETING</b>						
1.00	MARKETING		190.01	588,856	83,226	1.00
	TOTALS			588,856	83,226	
<b>F - MEDICAL SUPPLIES</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT		71.00	0	268,030	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT					2.00
	TOTALS			0	268,030	
<b>G - OXYGEN COST FOR RESPIRATORY THERAPY</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT		71.00	0	26,981	1.00
	TOTALS			0	26,981	
<b>H - AMBULANCE EXPENSE</b>						
1.00	ADULTS & PEDIATRICS		30.00	1,540	64,358	1.00
	TOTALS			1,540	64,358	
<b>I - INTEREST ON LINE OF CREDIT</b>						
1.00	CAP REL COSTS-BLDG & FIXT		1.00	0	11,306	1.00
	TOTALS			0	11,306	
<b>J - TELEMETRY IN PURCHASED SVC</b>						
1.00	ADULTS & PEDIATRICS		30.00	0	18,650	1.00
	TOTALS			0	18,650	
500.00	Grand Total: Increases			590,396	3,924,854	500.00

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
<b>A - FACILITY LEASE &amp; STORAGE EXPENSE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,750,566	10		1.00
	TOTALS		0	2,750,566			
<b>B - EQUIPMENT LEASE EXPENSE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00		34,134	10		1.00
2.00	OPERATION OF PLANT	7.00		275	0		2.00
3.00	DIETARY	10.00		508	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00		100,098	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00		206	0		5.00
6.00	ADULTS & PEDIATRICS	30.00		4,951	0		6.00
7.00	RESPIRATORY THERAPY	65.00		25,037	0		7.00
8.00	PHYSICAL THERAPY	66.00		447	0		8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00		52,406	0		9.00
	TOTALS		0	218,062			
<b>C - DEPRECIATION EXPENSE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00		10,905	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00		85,198	9		2.00
	TOTALS		0	96,103			
<b>D - CAPITAL INSURANCE &amp; PROPERTY TAX</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	21,572	12		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	366,000	13		2.00
	TOTALS		0	387,572			
<b>E - EXT CASE MANAGEMENT &amp; MARKETING</b>							
1.00	SOCIAL SERVICE	17.00	588,856	83,226	0		1.00
	TOTALS		588,856	83,226			
<b>F - MEDICAL SUPPLIES</b>							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	268,030	0		1.00
2.00	CENTRAL SERVICES & SUPPLY				0		2.00
	TOTALS		0	268,030			
<b>G - OXYGEN COST FOR RESPIRATORY THERAPY</b>							
1.00	RESPIRATORY THERAPY	65.00	0	26,981	0		1.00
	TOTALS		0	26,981			
<b>H - AMBULANCE EXPENSE</b>							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	1,540	64,358	0		1.00
	TOTALS		1,540	64,358			
<b>I - INTEREST ON LINE OF CREDIT</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11,306	11		1.00
	TOTALS		0	11,306			
<b>J - TELEMETRY IN PURCHASED SVC</b>							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	18,650	0		1.00
	TOTALS		0	18,650			
500.00	Grand Total: Decreases		590,396	3,924,854			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-3046

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/10/2024 1:04 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	67,418	134,005	0	134,005	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	520,417	54,510	0	54,510	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	587,835	188,515	0	188,515	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	587,835	188,515	0	188,515	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	201,423	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	574,927	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	776,350	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	776,350	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-3046

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/10/2024 1:04 pm

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-3046

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/10/2024 1:04 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	201,423	0	201,423	0.259449	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	574,927	0	574,927	0.740551	0	2.00
3.00	Total (sum of lines 1-2)	776,350	0	776,350	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	10,905	2,750,566	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	85,198	218,062	2.00
3.00	Total (sum of lines 1-2)	0	0	0	96,103	2,968,628	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	11,306	21,572	366,000	76,874	3,237,223	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	303,260	2.00
3.00	Total (sum of lines 1-2)	11,306	21,572	366,000	76,874	3,540,483	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-3046

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

Worksheet A-8

Date/Time Prepared:  
5/10/2024 1:04 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)			0		0.00		0	7.00
8.00 Television and radio service (chapter 21)			0		0.00		0	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-404,484					0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	92,466					0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests			0		0.00		0	14.00
15.00 Rental of quarters to employee and others			0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00		0	16.00
17.00 Sale of drugs to other than patients			0		0.00		0	17.00
18.00 Sale of medical records and abstracts			0		0.00		0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00		0	19.00
20.00 Vending machines			0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant			0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00		0	32.00
33.00 CAFETERIA REVENUE	B	-12,322	0	DIETARY	10.00		0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-3046

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

Worksheet A-8

Date/Time Prepared:  
5/10/2024 1:04 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
33.01 MR TRANSCRIPTION FEE	B	-3	MEDICAL RECORDS & LIBRARY	16.00	0 33.01
33.02 OTHER REVENUE	B	126	ADMINISTRATIVE & GENERAL	5.00	0 33.02
33.03 OTHER PHYSICIAN EXP. ADJ. (PER A-8-2)	A	-2,154	ADULTS & PEDIATRICS	30.00	0 33.03
33.04 BUSINESS MEALS ADJ.	A	-993	ADMINISTRATIVE & GENERAL	5.00	0 33.04
33.05 PATIENT PHONE ADJ.	A	-7,856	OPERATION OF PLANT	7.00	0 33.05
33.06 PATIENT TV ADJ.	A	-12,648	OPERATION OF PLANT	7.00	0 33.06
33.07 ADVERTISEMENT FEES ADJ.	A	0	ADMINISTRATIVE & GENERAL	5.00	0 33.07
33.08 ADVERTISEMENT FEES ADJ.	A	-8,244	MARKETING	190.01	0 33.08
33.09 SPONSORSHIP ADJ.	A	0	ADMINISTRATIVE & GENERAL	5.00	0 33.09
33.10 SPONSORSHIP ADJ.	A	-10,365	MARKETING	190.01	0 33.10
33.11 DUES & SUBSCRIPTIONS ADJ.	A	-4,590	ADMINISTRATIVE & GENERAL	5.00	0 33.11
33.12 STARTUP COST AMORTIZATION	A	88,828	ADMINISTRATIVE & GENERAL	5.00	0 33.12
33.13 AMBULANCE EXPENSE ADJ.	A	-80,542	RADIOLOGY-DIAGNOSTIC	54.00	0 33.13
33.14 LEGAL FEES ADJ.	A	0	ADMINISTRATIVE & GENERAL	5.00	0 33.14
33.15 PURCHASED SERVICES ADJ.	A	0	ADMINISTRATIVE & GENERAL	5.00	0 33.15
33.16 FREIGHT & SALES TAX ADJ.	A	0	CENTRAL SERVICES & SUPPLY	14.00	0 33.16
33.17 STATE OR LOCAL TAX ADJ.	A	-72,145	ADMINISTRATIVE & GENERAL	5.00	0 33.17
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-434,926			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: 15-3046

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

Worksheet A-8-1

Date/Time Prepared:  
5/10/2024 1:04 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	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE - CAPITAL	76,874	0
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - MGMT FEES	1,872,793	1,857,201
3.00	0.00			0	0
4.00	0.00			0	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,949,667	1,857,201

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

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

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

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

6.00	B	100.00	PAM CUBED, LLC	100.00	6.00
7.00		0.00		0.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 15-3046

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

Worksheet A-8-1

Date/Time Prepared:  
5/10/2024 1:04 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	76,874	14		1.00
2.00	15,592	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	92,466			5.00

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

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

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

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

6.00	HOSPITAL MGMT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-3046

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

Worksheet A-8-2

Date/Time Prepared:  
5/10/2024 1:04 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	589,925	298,250	291,675	197,500	1,953	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			589,925	298,250	291,675		1,953	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	185,441	9,272	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			185,441	9,272	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	185,441	106,234	404,484	1.00
2.00	0.00		0	0	0	0	2.00
3.00	0.00		0	0	0	0	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	185,441	106,234	404,484	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3046

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/10/2024 1:04 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	3,237,223	3,237,223			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	303,260		303,260		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	979,721	15,052	1,410	996,183	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,675,268	576,228	53,980	75,686	4,381,162 5.00
7.00 00700	OPERATION OF PLANT	719,784	86,399	8,094	19,211	833,488 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	209,706	43,377	4,064	0	257,147 8.00
9.00 00900	HOUSEKEEPING	441,993	0	0	33,914	475,907 9.00
10.00 01000	DIETARY	750,025	205,449	19,246	40,467	1,015,187 10.00
14.00 01400	CENTRAL SERVICES & SUPPLY	173,551	0	0	7,822	181,373 14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	244,650	17,837	1,671	16,725	280,883 16.00
17.00 01700	SOCIAL SERVICE	842,523	0	0	67,058	909,581 17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	4,961,306	1,637,307	153,381	380,786	7,132,780 30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY-DIAGNOSTIC	94,351	36,681	3,436	171	134,639 54.00
60.00 06000	LABORATORY	50,640	8,711	816	17	60,184 60.00
65.00 06500	RESPIRATORY THERAPY	458,315	17,718	1,660	37,904	515,597 65.00
66.00 06600	PHYSICAL THERAPY	1,494,072	275,788	25,836	123,337	1,919,033 66.00
67.00 06700	OCCUPATIONAL THERAPY	1,005,359	220,085	20,617	83,832	1,329,893 67.00
68.00 06800	SPEECH PATHOLOGY	280,520	41,066	3,847	23,257	348,690 68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	295,011	0	0	0	295,011 71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	863,280	55,525	5,202	0	924,007 73.00
74.00 07400	RENAL DIALYSIS	233,809	0	0	16,500	250,309 74.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	21,314,367	3,237,223	303,260	926,687	21,244,871 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
190.01 19001	MARKETING	902,659	0	0	69,496	972,155 190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
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)	22,217,026	3,237,223	303,260	996,183	22,217,026 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3046

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/10/2024 1:04 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,381,162				5.00
7.00	00700	OPERATION OF PLANT	204,736	1,038,224			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	63,165	17,595	337,907		8.00
9.00	00900	HOUSEKEEPING	116,901	0	0	592,808	9.00
10.00	01000	DIETARY	249,369	83,336	0	48,404	1,396,296
14.00	01400	CENTRAL SERVICES & SUPPLY	44,552	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	68,996	7,235	0	4,202	0
17.00	01700	SOCIAL SERVICE	223,428	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,752,079	664,137	337,907	385,749	1,396,296
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,072	14,879	0	8,642	0
60.00	06000	LABORATORY	14,783	3,533	0	2,052	0
65.00	06500	RESPIRATORY THERAPY	126,650	7,187	0	4,174	0
66.00	06600	PHYSICAL THERAPY	471,387	111,868	0	64,976	0
67.00	06700	OCCUPATIONAL THERAPY	326,672	89,273	0	51,852	0
68.00	06800	SPEECH PATHOLOGY	85,652	16,658	0	9,675	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	72,466	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	226,971	22,523	0	13,082	0
74.00	07400	RENAL DIALYSIS	61,485	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,142,364	1,038,224	337,907	592,808	1,396,296
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
190.01	19001	MARKETING	238,798	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	4,381,162	1,038,224	337,907	592,808	1,396,296

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3046

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/10/2024 1:04 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	16.00	17.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
14.00	01400	225,925					14.00
16.00	01600	75	361,391				16.00
17.00	01700	889	0	1,133,898			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	11,504	158,813	1,133,898	12,973,163	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	0	2,305	0	193,537	0	54.00
60.00	06000	0	9,517	0	90,069	0	60.00
65.00	06500	3,380	29,173	0	686,161	0	65.00
66.00	06600	10,569	60,883	0	2,638,716	0	66.00
67.00	06700	0	35,975	0	1,833,665	0	67.00
68.00	06800	728	7,349	0	468,752	0	68.00
71.00	07100	169,836	16,803	0	554,116	0	71.00
73.00	07300	2,903	33,417	0	1,222,903	0	73.00
74.00	07400	17,677	7,156	0	336,627	0	74.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		217,561	361,391	1,133,898	20,997,709	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	8,364	0	0	1,219,317	0	190.01
192.00	19200	0	0	0	0	0	192.00
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		225,925	361,391	1,133,898	22,217,026	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3046

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/10/2024 1:04 pm

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
190.01	19001	MARKETING	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3046

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/10/2024 1:04 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	15,052	1,410	16,462	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	576,228	53,980	630,208	5.00
7.00 00700	OPERATION OF PLANT	0	86,399	8,094	94,493	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	43,377	4,064	47,441	8.00
9.00 00900	HOUSEKEEPING	0	0	0	0	9.00
10.00 01000	DIETARY	0	205,449	19,246	224,695	10.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	17,837	1,671	19,508	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	1,637,307	153,381	1,790,688	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	36,681	3,436	40,117	54.00
60.00 06000	LABORATORY	0	8,711	816	9,527	60.00
65.00 06500	RESPIRATORY THERAPY	0	17,718	1,660	19,378	65.00
66.00 06600	PHYSICAL THERAPY	0	275,788	25,836	301,624	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	220,085	20,617	240,702	67.00
68.00 06800	SPEECH PATHOLOGY	0	41,066	3,847	44,913	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	55,525	5,202	60,727	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	3,237,223	303,260	3,540,483	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01 19001	MARKETING	0	0	0	0	190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	3,237,223	303,260	3,540,483	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-3046		Period: From 01/01/2023 To 12/31/2023		Worksheet B Part II Date/Time Prepared: 5/10/2024 1:04 pm	
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	631,459					5.00
7.00	00700	OPERATION OF PLANT	29,509	124,319				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,104	2,107	58,652			8.00
9.00	00900	HOUSEKEEPING	16,849	0	0	17,409		9.00
10.00	01000	DIETARY	35,942	9,979	0	1,421	272,706	10.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,421	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,944	866	0	123	0	16.00
17.00	01700	SOCIAL SERVICE	32,203	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	252,526	79,524	58,652	11,329	272,706	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,767	1,782	0	254	0	54.00
60.00	06000	LABORATORY	2,131	423	0	60	0	60.00
65.00	06500	RESPIRATORY THERAPY	18,254	861	0	123	0	65.00
66.00	06600	PHYSICAL THERAPY	67,941	13,395	0	1,908	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	47,084	10,690	0	1,523	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,345	1,995	0	284	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,445	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,714	2,697	0	384	0	73.00
74.00	07400	RENAL DIALYSIS	8,862	0	0	0	0	74.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	597,041	124,319	58,652	17,409	272,706	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	MARKETING	34,418	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	631,459	124,319	58,652	17,409	272,706	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3046

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/10/2024 1:04 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	16.00	17.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
14.00	01400	6,550					14.00
16.00	01600	2	30,719				16.00
17.00	01700	26	0	33,337			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	334	13,493	33,337	2,518,884	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	0	196	0	47,119	0	54.00
60.00	06000	0	809	0	12,950	0	60.00
65.00	06500	98	2,481	0	41,821	0	65.00
66.00	06600	306	5,177	0	392,389	0	66.00
67.00	06700	0	3,059	0	304,443	0	67.00
68.00	06800	21	625	0	60,567	0	68.00
71.00	07100	4,925	1,429	0	16,799	0	71.00
73.00	07300	84	2,842	0	99,448	0	73.00
74.00	07400	512	608	0	10,255	0	74.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		6,308	30,719	33,337	3,504,675	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	242	0	0	35,808	0	190.01
192.00	19200	0	0	0	0	0	192.00
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		6,550	30,719	33,337	3,540,483	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3046

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/10/2024 1:04 pm

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
190.01	19001	MARKETING	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-3046

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

Worksheet B-1  
Date/Time Prepared:  
5/10/2024 1:04 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	54,629				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		54,629			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	254	254	10,988,363		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	9,724	9,724	834,852	-4,381,162	17,835,864
7.00 00700	OPERATION OF PLANT	1,458	1,458	211,910	0	833,488
8.00 00800	LAUNDRY & LINEN SERVICE	732	732	0	0	257,147
9.00 00900	HOUSEKEEPING	0	0	374,082	0	475,907
10.00 01000	DIETARY	3,467	3,467	446,371	0	1,015,187
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	86,276	0	181,373
16.00 01600	MEDICAL RECORDS & LIBRARY	301	301	184,487	0	280,883
17.00 01700	SOCIAL SERVICE	0	0	739,681	0	909,581
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	27,630	27,630	4,200,257	0	7,132,780
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY-DIAGNOSTIC	619	619	1,882	0	134,639
60.00 06000	LABORATORY	147	147	190	0	60,184
65.00 06500	RESPIRATORY THERAPY	299	299	418,101	0	515,597
66.00 06600	PHYSICAL THERAPY	4,654	4,654	1,360,470	0	1,919,033
67.00 06700	OCCUPATIONAL THERAPY	3,714	3,714	924,702	0	1,329,893
68.00 06800	SPEECH PATHOLOGY	693	693	256,533	0	348,690
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	295,011
73.00 07300	DRUGS CHARGED TO PATIENTS	937	937	0	0	924,007
74.00 07400	RENAL DIALYSIS	0	0	182,001	0	250,309
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	54,629	54,629	10,221,795	-4,381,162	16,863,709
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
190.01 19001	MARKETING	0	0	766,568	0	972,155
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	3,237,223	303,260	996,183		4,381,162
203.00	Unit cost multiplier (Wkst. B, Part I)	59.258324	5.551264	0.090658		0.245638
204.00	Cost to be allocated (per Wkst. B, Part II)			16,462		631,459
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001498		0.035404
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-3046

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

Worksheet B-1

Date/Time Prepared:  
5/10/2024 1:04 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		7.00	8.00	9.00	10.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700	43,193					7.00
8.00	00800	732	14,282				8.00
9.00	00900	0	0	42,461			9.00
10.00	01000	3,467	0	3,467	14,282		10.00
14.00	01400	0	0	0	0	356,550	14.00
16.00	01600	301	0	301	0	119	16.00
17.00	01700	0	0	0	0	1,403	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	27,630	14,282	27,630	14,282	18,155	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	619	0	619	0	0	54.00
60.00	06000	147	0	147	0	0	60.00
65.00	06500	299	0	299	0	5,334	65.00
66.00	06600	4,654	0	4,654	0	16,680	66.00
67.00	06700	3,714	0	3,714	0	0	67.00
68.00	06800	693	0	693	0	1,149	68.00
71.00	07100	0	0	0	0	268,030	71.00
73.00	07300	937	0	937	0	4,582	73.00
74.00	07400	0	0	0	0	27,898	74.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		43,193	14,282	42,461	14,282	343,350	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	0	13,200	190.01
192.00	19200	0	0	0	0	0	192.00
200.00							200.00
201.00							201.00
202.00		1,038,224	337,907	592,808	1,396,296	225,925	202.00
203.00		24.036858	23.659642	13.961235	97.766139	0.633642	203.00
204.00		124,319	58,652	17,409	272,706	6,550	204.00
205.00		2.878221	4.106708	0.410000	19.094385	0.018370	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-3046

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

Worksheet B-1

Date/Time Prepared:  
5/10/2024 1:04 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100			1.00
2.00	00200			2.00
4.00	00400			4.00
5.00	00500			5.00
7.00	00700			7.00
8.00	00800			8.00
9.00	00900			9.00
10.00	01000			10.00
14.00	01400			14.00
16.00	01600	51,907,494		16.00
17.00	01700		14,282	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	22,809,701	14,282	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
54.00	05400	331,132	0	54.00
60.00	06000	1,366,980	0	60.00
65.00	06500	4,190,249	0	65.00
66.00	06600	8,745,074	0	66.00
67.00	06700	5,167,392	0	67.00
68.00	06800	1,055,657	0	68.00
71.00	07100	2,413,596	0	71.00
73.00	07300	4,799,913	0	73.00
74.00	07400	1,027,800	0	74.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00		51,907,494	14,282	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	0	0	190.00
190.01	19001	0	0	190.01
192.00	19200	0	0	192.00
200.00				200.00
201.00				201.00
202.00		361,391	1,133,898	202.00
203.00		0.006962	79.393502	203.00
204.00		30,719	33,337	204.00
205.00		0.000592	2.334197	205.00
206.00				206.00
207.00				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-3046

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/10/2024 1:04 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE		Total Costs
					Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	12,973,163		12,973,163	106,234	13,079,397	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	193,537		193,537	0	193,537	54.00
60.00	06000 LABORATORY	90,069		90,069	0	90,069	60.00
65.00	06500 RESPIRATORY THERAPY	686,161	0	686,161	0	686,161	65.00
66.00	06600 PHYSICAL THERAPY	2,638,716	0	2,638,716	0	2,638,716	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,833,665	0	1,833,665	0	1,833,665	67.00
68.00	06800 SPEECH PATHOLOGY	468,752	0	468,752	0	468,752	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	554,116		554,116	0	554,116	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,222,903		1,222,903	0	1,222,903	73.00
74.00	07400 RENAL DIALYSIS	336,627		336,627	0	336,627	74.00
200.00	Subtotal (see instructions)	20,997,709	0	20,997,709	106,234	21,103,943	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	20,997,709	0	20,997,709	106,234	21,103,943	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-3046

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/10/2024 1:04 pm

Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
Title XVIII Hospital PPS								
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,809,701		22,809,701			30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	331,132	0	331,132	0.584471	0.000000	54.00
60.00	06000	LABORATORY	1,366,980	0	1,366,980	0.065889	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	4,190,249	0	4,190,249	0.163752	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,860,707	1,884,367	8,745,074	0.301737	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,512,054	655,338	5,167,392	0.354853	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	955,805	99,852	1,055,657	0.444038	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,413,596	0	2,413,596	0.229581	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,799,913	0	4,799,913	0.254776	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,027,800	0	1,027,800	0.327522	0.000000	74.00
200.00		Subtotal (see instructions)	49,267,937	2,639,557	51,907,494			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	49,267,937	2,639,557	51,907,494			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/10/2024 1:04 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
	ANCILLARY SERVICE COST CENTERS			
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.584471		54.00
60.00	06000 LABORATORY	0.065889		60.00
65.00	06500 RESPIRATORY THERAPY	0.163752		65.00
66.00	06600 PHYSICAL THERAPY	0.301737		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.354853		67.00
68.00	06800 SPEECH PATHOLOGY	0.444038		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.229581		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.254776		73.00
74.00	07400 RENAL DIALYSIS	0.327522		74.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-3046

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/10/2024 1:04 pm

		Title XIX		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00		4.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	12,973,163		12,973,163	106,234	13,079,397	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400 RADIOLOGY-DIAGNOSTIC	193,537		193,537	0	193,537	54.00
60.00	06000 LABORATORY	90,069		90,069	0	90,069	60.00
65.00	06500 RESPIRATORY THERAPY	686,161	0	686,161	0	686,161	65.00
66.00	06600 PHYSICAL THERAPY	2,638,716	0	2,638,716	0	2,638,716	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,833,665	0	1,833,665	0	1,833,665	67.00
68.00	06800 SPEECH PATHOLOGY	468,752	0	468,752	0	468,752	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	554,116		554,116	0	554,116	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,222,903		1,222,903	0	1,222,903	73.00
74.00	07400 RENAL DIALYSIS	336,627		336,627	0	336,627	74.00
200.00	Subtotal (see instructions)	20,997,709	0	20,997,709	106,234	21,103,943	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	20,997,709	0	20,997,709	106,234	21,103,943	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-3046

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/10/2024 1:04 pm

			Title XIX			Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio				
	Inpatient	Outpatient	Total (col. 6 + col. 7)						
	6.00	7.00	8.00				9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	22,809,701		22,809,701			30.00	
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	331,132	0	331,132	0.584471	0.000000	54.00	
60.00	06000	LABORATORY	1,366,980	0	1,366,980	0.065889	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	4,190,249	0	4,190,249	0.163752	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	6,860,707	1,884,367	8,745,074	0.301737	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	4,512,054	655,338	5,167,392	0.354853	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	955,805	99,852	1,055,657	0.444038	0.000000	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,413,596	0	2,413,596	0.229581	0.000000	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,799,913	0	4,799,913	0.254776	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	1,027,800	0	1,027,800	0.327522	0.000000	74.00	
200.00		Subtotal (see instructions)	49,267,937	2,639,557	51,907,494			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	49,267,937	2,639,557	51,907,494			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/10/2024 1:04 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital
		11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.584471		54.00
60.00	06000 LABORATORY	0.065889		60.00
65.00	06500 RESPIRATORY THERAPY	0.163752		65.00
66.00	06600 PHYSICAL THERAPY	0.301737		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.354853		67.00
68.00	06800 SPEECH PATHOLOGY	0.444038		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.229581		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.254776		73.00
74.00	07400 RENAL DIALYSIS	0.327522		74.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 15-3046

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

Worksheet C  
Part II  
Date/Time Prepared:  
5/10/2024 1:04 pm

Cost Center Description			Title XIX			Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	193,537	47,119	146,418	0	0	54.00
60.00	06000	LABORATORY	90,069	12,950	77,119	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	686,161	41,821	644,340	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,638,716	392,389	2,246,327	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,833,665	304,443	1,529,222	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	468,752	60,567	408,185	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	554,116	16,799	537,317	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,222,903	99,448	1,123,455	0	0	73.00
74.00	07400	RENAL DIALYSIS	336,627	10,255	326,372	0	0	74.00
200.00		Subtotal (sum of lines 50 thru 199)	8,024,546	985,791	7,038,755	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	8,024,546	985,791	7,038,755	0	0	202.00

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

Provider CCN: 15-3046

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

Worksheet C  
Part II  
Date/Time Prepared:  
5/10/2024 1:04 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	193,537	331,132	0.584471	54.00
60.00	06000	LABORATORY	90,069	1,366,980	0.065889	60.00
65.00	06500	RESPIRATORY THERAPY	686,161	4,190,249	0.163752	65.00
66.00	06600	PHYSICAL THERAPY	2,638,716	8,745,074	0.301737	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,833,665	5,167,392	0.354853	67.00
68.00	06800	SPEECH PATHOLOGY	468,752	1,055,657	0.444038	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	554,116	2,413,596	0.229581	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,222,903	4,799,913	0.254776	73.00
74.00	07400	RENAL DIALYSIS	336,627	1,027,800	0.327522	74.00
200.00		Subtotal (sum of lines 50 thru 199)	8,024,546	29,097,793		200.00
201.00		Less Observation Beds	0	0		201.00
202.00		Total (line 200 minus line 201)	8,024,546	29,097,793		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-3046		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part I Date/Time Prepared: 5/10/2024 1:04 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,518,884	0	2,518,884	14,282	176.37	30.00
200.00	Total (lines 30 through 199)	2,518,884		2,518,884	14,282		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	11,218	1,978,519				
200.00	Total (lines 30 through 199)	11,218	1,978,519				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prepared: 5/10/2024 1:04 pm
--	-----------------------	---	--

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	
Title XVIII Hospital PPS								
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,119	331,132	0.142297	213,993	30,451	54.00
60.00	06000	LABORATORY	12,950	1,366,980	0.009473	923,304	8,746	60.00
65.00	06500	RESPIRATORY THERAPY	41,821	4,190,249	0.009981	3,240,900	32,347	65.00
66.00	06600	PHYSICAL THERAPY	392,389	8,745,074	0.044870	5,439,973	244,092	66.00
67.00	06700	OCCUPATIONAL THERAPY	304,443	5,167,392	0.058916	3,540,087	208,568	67.00
68.00	06800	SPEECH PATHOLOGY	60,567	1,055,657	0.057374	675,512	38,757	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,799	2,413,596	0.006960	1,858,281	12,934	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	99,448	4,799,913	0.020719	3,774,741	78,209	73.00
74.00	07400	RENAL DIALYSIS	10,255	1,027,800	0.009978	741,600	7,400	74.00
200.00		Total (lines 50 through 199)	985,791	29,097,793		20,408,391	661,504	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-3046		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part III Date/Time Prepared: 5/10/2024 1:04 pm		
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	14,282	0.00	11,218	30.00	
200.00		Total (lines 30 through 199)	0	0	14,282		11,218	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/10/2024 1:04 pm
--	-----------------------	---	--

Cost Center Description	Title XVIII			Hospital		PPS	
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/10/2024 1:04 pm
--	-----------------------	---	--

Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	Title XVIII	
						Hospital	PPS
	4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS							
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	331,132	0.000000		54.00
60.00 06000 LABORATORY	0	0	0	1,366,980	0.000000		60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	4,190,249	0.000000		65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	8,745,074	0.000000		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	5,167,392	0.000000		67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	1,055,657	0.000000		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,413,596	0.000000		71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	4,799,913	0.000000		73.00
74.00 07400 RENAL DIALYSIS	0	0	0	1,027,800	0.000000		74.00
200.00 Total (lines 50 through 199)	0	0	0	29,097,793			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3046

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/10/2024 1:04 pm

Cost Center Description			Title XVIII			Hospital		PPS	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00	10.00	11.00	12.00		13.00	
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	213,993	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	923,304	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,240,900	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	5,439,973	0	664	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	3,540,087	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	675,512	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,858,281	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,774,741	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	741,600	0	0	0	0	74.00
200.00		Total (lines 50 through 199)		20,408,391	0	664	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-3046

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

Worksheet D  
Part V  
Date/Time Prepared:  
5/10/2024 1:04 pm

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.584471	0	0	0	54.00
60.00	06000	LABORATORY	0.065889	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.163752	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.301737	664	0	0	200 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.354853	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.444038	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.229581	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.254776	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.327522	0	0	0	74.00
200.00		Subtotal (see instructions)		664	0	0	200 200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 - line 201)		664	0	0	200 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/10/2024 1:04 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCI LLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (Line 200 - Line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-3046		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part I Date/Time Prepared: 5/10/2024 1:04 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,518,884	0	2,518,884	14,282	176.37	
200.00	Total (lines 30 through 199)	2,518,884		2,518,884	14,282	200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	0	0	30.00			
200.00	Total (lines 30 through 199)	0	0	200.00			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prepared: 5/10/2024 1:04 pm
--	-----------------------	---	--

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)	Hospital Inpatient Program Charges	PPS Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400 RADIOLOGY-DIAGNOSTIC	47,119	331,132	0.142297	0	0	54.00
60.00	06000 LABORATORY	12,950	1,366,980	0.009473	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	41,821	4,190,249	0.009981	0	0	65.00
66.00	06600 PHYSICAL THERAPY	392,389	8,745,074	0.044870	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	304,443	5,167,392	0.058916	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	60,567	1,055,657	0.057374	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	16,799	2,413,596	0.006960	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	99,448	4,799,913	0.020719	0	0	73.00
74.00	07400 RENAL DIALYSIS	10,255	1,027,800	0.009978	0	0	74.00
200.00	Total (lines 50 through 199)	985,791	29,097,793		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-3046		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part III Date/Time Prepared: 5/10/2024 1:04 pm	
Cost Center Description			Title XIX		Hospital		PPS	
			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of 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	14,282	0.00	0	30.00
200.00		Total (lines 30 through 199)	0	0	14,282		0	200.00
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
			9.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0					30.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/10/2024 1:04 pm
--	-----------------------	---	--

Cost Center Description	Title XIX			Hospital		Allied Health Post-Stepdown Adjustments	Allied Health PPS	
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program					
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
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: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/10/2024 1:04 pm
--	-----------------------	---	--

Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Title XIX		Hospital		PPS	
				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									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	331,132	0.000000		54.00
60.00	06000	LABORATORY	0	0	0	1,366,980	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,190,249	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,745,074	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,167,392	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,055,657	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,413,596	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,799,913	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,027,800	0.000000		74.00
200.00		Total (lines 50 through 199)	0	0	0	29,097,793			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/10/2024 1:04 pm
--	-----------------------	---	--

Cost Center Description	Title XIX			Hospital		PPS	
	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
	9.00	10.00	11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	74.00
200.00		Total (lines 50 through 199)		0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/10/2024 1:04 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,282	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,282	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)		14,282	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		11,218	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		13,079,397	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)		13,079,397	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		13,079,397	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		915.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		10,273,444	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)		10,273,444	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/10/2024 1:04 pm	
Cost Center Description			Title XVIII		Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				5,545,446	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)				15,818,890	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)				1,978,519	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				661,504	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				2,640,023	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				13,178,867	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
55.01	Permanent adjustment amount per discharge				0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)				0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)				0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	57.00
58.00	Bonus payment (see instructions)				0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)				0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)				0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)				0	61.00
62.00	Relief payment (see instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions				0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3046		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/10/2024 1:04 pm	
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	2,518,884	13,079,397	0.192584	0	0	90.00
91.00	Nursing Program cost	0	13,079,397	0.000000	0	0	91.00
92.00	Allied health cost	0	13,079,397	0.000000	0	0	92.00
93.00	All other Medical Education	0	13,079,397	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/10/2024 1:04 pm
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,282	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,282	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)		14,282	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		13,079,397	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)		13,079,397	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		13,079,397	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		915.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	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)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/10/2024 1:04 pm	
Cost Center Description			Title XIX		Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0 48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0 48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					0 49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0 54.00
55.00	Target amount per discharge					0.00 55.00
55.01	Permanent adjustment amount per discharge					0.00 55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00 55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00	Bonus payment (see instructions)					0 58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00 59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00 60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0 61.00
62.00	Relief payment (see instructions)					0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3046		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/10/2024 1:04 pm	
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	2,518,884	13,079,397	0.192584	0	0	90.00
91.00	Nursing Program cost	0	13,079,397	0.000000	0	0	91.00
92.00	Allied health cost	0	13,079,397	0.000000	0	0	92.00
93.00	All other Medical Education	0	13,079,397	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/10/2024 1:04 pm	
Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		17,897,485		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.584471	213,993	125,073	54.00
60.00	06000 LABORATORY	0.065889	923,304	60,836	60.00
65.00	06500 RESPIRATORY THERAPY	0.163752	3,240,900	530,704	65.00
66.00	06600 PHYSICAL THERAPY	0.301737	5,439,973	1,641,441	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.354853	3,540,087	1,256,210	67.00
68.00	06800 SPEECH PATHOLOGY	0.444038	675,512	299,953	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.229581	1,858,281	426,626	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.254776	3,774,741	961,713	73.00
74.00	07400 RENAL DIALYSIS	0.327522	741,600	242,890	74.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		20,408,391	5,545,446	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		20,408,391		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/10/2024 1:04 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			0	30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.584471		0	54.00
60.00	06000 LABORATORY	0.065889		0	60.00
65.00	06500 RESPIRATORY THERAPY	0.163752		0	65.00
66.00	06600 PHYSICAL THERAPY	0.301737		0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.354853		0	67.00
68.00	06800 SPEECH PATHOLOGY	0.444038		0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.229581		0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.254776		0	73.00
74.00	07400 RENAL DIALYSIS	0.327522		0	74.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			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: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/10/2024 1:04 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		200	2.00
3.00	OPPS or REH payments		134	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		134	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		27	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)		107	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)		107	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		107	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		107	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.75	N95 respirator payment adjustment amount (see instructions)		0	39.75
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		107	40.00
40.01	Sequestration adjustment (see instructions)		2	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		105	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)		0	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
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/10/2024 1:04 pm
		Title XVIII	Hospital	PPS
				1.00
94.00	Total (sum of lines 91 and 93)			0 94.00
				1.00
200.00	MEDICARE PART B ANCILLARY COSTS Part B Combined Billed Days			0 200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-3046

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/10/2024 1:04 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		23,723,159		105	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)		23,723,159		105	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		125,229		0	6.02
7.00	Total Medicare program liability (see instructions)		23,597,930		105	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part III Date/Time Prepared: 5/10/2024 1:04 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)		24,383,783	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0300	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		229,208	3.00
4.00	Outlier Payments		14,081	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	5.01
6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)		39.128767	10.00
11.00	Teaching Adjustment Factor (see instructions)		0.000000	11.00
12.00	Teaching Adjustment (see instructions)		0	12.00
13.00	Total PPS Payment (see instructions)		24,627,072	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		0	15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)		0	16.00
17.00	Subtotal (see instructions)		24,627,072	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		24,627,072	19.00
20.00	Deductibles		546,672	20.00
21.00	Subtotal (line 19 minus line 20)		24,080,400	21.00
22.00	Coinsurance		86,345	22.00
23.00	Subtotal (line 21 minus line 22)		23,994,055	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		131,485	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		85,465	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		103,081	26.00
27.00	Subtotal (sum of lines 23 and 25)		24,079,520	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	28.00
29.00	Other pass through costs (see instructions)		0	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS		0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	31.50
31.98	Recovery of accelerated depreciation.		0	31.98
31.99	Demonstration payment adjustment amount before sequestration		0	31.99
32.00	Total amount payable to the provider (see instructions)		24,079,520	32.00
32.01	Sequestration adjustment (see instructions)		481,590	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		23,723,159	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)		-125,229	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4		14,081	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00
<b>FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)</b>				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.		0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)		0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-3046	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/10/2024 1:04 pm	
		Title XIX	Hospital	PPS	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
<b>CUSTOMARY CHARGES</b>					
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)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 15-3046

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

Worksheet G

Date/Time Prepared:  
5/10/2024 1:04 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	42,955	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,177,275	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-90,229	0	0	0	6.00
7.00	Inventory	29,350	0	0	0	7.00
8.00	Prepaid expenses	202,405	0	0	0	8.00
9.00	Other current assets	-313,519	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)	2,048,237	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	201,423	0	0	0	17.00
18.00	Accumulated depreciation	-14,058	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	574,927	0	0	0	23.00
24.00	Accumulated depreciation	-129,374	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	632,918	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	45,978,470	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	45,978,470	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	48,659,625	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	692,913	0	0	0	37.00
38.00	Salaries, wages, and fees payable	608,782	0	0	0	38.00
39.00	Payroll taxes payable	25,149	0	0	0	39.00
40.00	Notes and loans payable (short term)	162,428	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	371,002	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,860,274	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	37,559,856	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	37,559,856	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	39,420,130	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	9,239,495	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	9,239,495	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	48,659,625	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-3046

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

Worksheet G-1

Date/Time Prepared:  
5/10/2024 1:04 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		9,770,157		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		8,301,391			2.00
3.00	Total (sum of line 1 and line 2)		18,071,548		0	3.00
4.00	ROUNDING	1		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		1		0	10.00
11.00	Subtotal (line 3 plus line 10)		18,071,549		0	11.00
12.00	EQUITY TRANSFER	8,832,054		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		8,832,054		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		9,239,495		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	ROUNDING		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	EQUITY TRANSFER		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: 15-3046

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/10/2024 1:04 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	22,809,701		22,809,701	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)	22,809,701		22,809,701	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	22,809,701		22,809,701	17.00
18.00	Ancillary services	26,458,236		26,458,236	18.00
19.00	Outpatient services	0	2,639,557	2,639,557	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	49,267,937	2,639,557	51,907,494	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		22,651,952		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)		22,651,952		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-3046

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

Worksheet G-3

Date/Time Prepared:  
5/10/2024 1:04 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	51,907,494	1.00
2.00	Less contractual allowances and discounts on patients' accounts	20,966,349	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,941,145	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,651,952	4.00
5.00	Net income from service to patients (line 3 minus line 4)	8,289,193	5.00
<b>OTHER INCOME</b>			
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	12,322	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	3	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	-126	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	12,199	25.00
26.00	Total (line 5 plus line 25)	8,301,392	26.00
27.00	ROUNDING	1	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	1	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	8,301,391	29.00