

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: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/28/2024 1: 29 pm
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<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 5/28/2024	Time: 1: 29 pm
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)**  
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PARKVIEW - DEKALB HEALTH ( 15-0045 ) 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>Jeanne Wickens</b>	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification to be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Jeanne Wickens		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	70,891	22,038	0	0 1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	0 2.00
3.00	SUBPROVIDER - IRF	0	0	0	0	0 3.00
5.00	SWING BED - SNF	0	0	0	0	0 5.00
6.00	SWING BED - NF	0	0	0	0	0 6.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	0 9.00
200.00	TOTAL	0	70,891	22,038	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: 15-0045		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/28/2024 1:29 pm						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1316 EAST 7TH STREET			PO Box:						1.00		
2.00	City: AUBURN			State: IN		Zip Code: 46706-		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		
Hospital and Hospital -Based Component Identification:												
3.00	Hospital		PARKVIEW - DEKALB HEALTH		150045	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital -Based SNF											9.00
10.00	Hospital -Based NF											10.00
11.00	Hospital -Based OLTC											11.00
12.00	Hospital -Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital -Based Hospice											14.00
15.00	Hospital -Based Health Clinic - RHC											15.00
16.00	Hospital -Based Health Clinic - FQHC											16.00
17.00	Hospital -Based (CMHC) I											17.00
17.10	Hospital -Based (CORF) I											17.10
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)						2		21.00			
							1.00	2.00	3.00			
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00			
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					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)					N	N		22.03			
22.04	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			
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)								22.04			
22.04	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.								22.04			
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0045			Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/28/2024 1:29 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.	77	15	0	0	783	30		24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0			25.00
						Urban/Rural	S	Date of Geogr	
						1.00		2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					Y	Y		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you 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

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		V	XVIII	XIX		
		1.00	2.00	3.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	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
61.01	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 baseline 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
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
<b>Teaching Hospitals that Claim Residents in Nonprovider Settings</b>						
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

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			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	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 Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col . 3/ (col . 3 + col . 4))
			1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col . 1/ (col . 1 + col . 2))		
			1.00	2.00	3.00		
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 Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col . 3/ (col . 3 + col . 4))
			1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/28/2024 1:29 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.			N	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0 76.00	
			1.00		
<b>Long Term Care Hospital PPS</b>					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
<b>TEFRA Providers</b>					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N	86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
			1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.			N	0 88.00
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge
			1.00	2.00	3.00
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.			0.00	0 89.00
			V	XIX	
			1.00	2.00	
<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	Y 90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	Y 91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	N 92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N 93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N 94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00 95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N 96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00 97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0045		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/28/2024 1:29 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. 1, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y			98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y			98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. 1V, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y			98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N			98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N			98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. 1, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y			98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. 1 through 1V? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y			98.06	
<b>Rural Providers</b>							
105.00	Does this hospital qualify as a CAH?	N				105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00	
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)					107.01	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical 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.	N	N	N	N	109.00	
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.					N	110.00
						1.00 2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
						1.00 2.00 3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.		N			112.00	
<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			0115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/28/2024 1:29 pm	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	93,717	458	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	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.		Y	Y	123.00
<b>Certified Transplant Center Information</b>					
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	Removed and reserved				133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
<b>All Providers</b>					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: PARKVIEW HEALTH SYSTEM INC.	Contractor's Name: WPS	Contractor's Number: 08101		141.00
142.00	Street: 1450 PRODUCTION ROAD	PO Box:			142.00
143.00	City: FORT WAYNE	State: IN	Zip Code: 46808		143.00
		1.00	2.00		
144.00	Are provider based physicians' costs included in Worksheet A?		Y		144.00
		1.00	2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00



HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0045		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part II Date/Time Prepared: 5/28/2024 1:29 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.							
<b>COMPLETED BY ALL HOSPITALS</b>							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
				Y/N	Date		V/I
				1.00	2.00		3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
				Y/N	Type		Date
				1.00	2.00		3.00
<b>Financial Data and Reports</b>							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y		A			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
				Y/N	Legal Oper.		
				1.00	2.00		
<b>Approved Educational Activities</b>							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
<b>Bad Debts</b>							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N			14.00
<b>Bed Complement</b>							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y			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	05/10/2024	Y	05/10/2024		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: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/28/2024 1:29 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
<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.			Y	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.				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?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
<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.	SHANNON		ECENBARGER	41.00
42.00	Enter the employer/company name of the cost report preparer.	PARKVIEW HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	2604377558		REIMBURSEMENT@PARKVIEW.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0045

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		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.	DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0045

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/28/2024 1:29 pm

Component	Worksheet A Line No.	No. of Beds	Bed Days Avai lable	CAH/REH Hours	I/P Days / O/P Vi s i t s / Tri ps		
					Ti tle V		
	1.00	2.00	3.00	4.00	5.00		
<b>PART I - STATISTICAL DATA</b>							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	40	14,600	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		40	14,600	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		48	17,520	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	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10				0	25.10
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)		48				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: 15-0045

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Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	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)	812	57	2,790		1.00
2.00	HMO and other (see instructions)	1,526	798			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0	0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	812	57	2,790		7.00
8.00	INTENSIVE CARE UNIT	157	0	1,129		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		20	362		13.00
14.00	Total (see instructions)	969	77	4,281	0.00	239.06
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	0	0	0	0.00	0.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE	0	0	0	0.00	0.00
24.10	HOSPICE (non-distinct part)			51		24.10
25.00	CMHC - CMHC					25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00
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	239.06
28.00	Observation Bed Days		58	2,647		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	30	64		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: 15-0045

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Part I  
Date/Time Prepared:  
5/28/2024 1:29 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	357	32	1,558	1.00
2.00	HMO and other (see instructions)			537	374		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	357	32	1,558	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0045

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/28/2024 1:29 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	19,400,834	5,735,241	25,136,075	646,711.32	38.87
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		5,735,241	0	5,735,241	149,463.00	38.37
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,928,730	258,081	2,186,811	62,730.00	34.86
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		0	0	0	0.00	0.00
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		5,735,241	0	5,735,241	149,463.00	38.37
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		7,931,473	0	7,931,473		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		996,684	0	996,684		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		3,030,864	0	3,030,864		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0045

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/28/2024 1:29 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	2,289,632	-2,289,632	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	822,438	5,845,291	6,667,729	160,760.08	41.48	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	595,703	79,710	675,413	18,836.95	35.86	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	811,672	108,609	920,281	38,367.53	23.99	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	540,818	-209,966	330,852	12,976.01	25.50	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	282,332	282,332	12,694.32	22.24	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	433,909	58,061	491,970	9,185.05	53.56	38.00
39.00	Central Services and Supply	14.00	79,291	10,610	89,901	4,423.01	20.33	39.00
40.00	Pharmacy	15.00	567,935	75,995	643,930	9,533.75	67.54	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0045

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/28/2024 1:29 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Pai d Hours Related to Sal ari es i n col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	13,665,593	5,735,241	19,400,834	497,248.32	39.02	1.00
2.00	Excluded area salaries (see instructions)	1,928,730	258,081	2,186,811	62,730.00	34.86	2.00
3.00	Subtotal salaries (line 1 minus line 2)	11,736,863	5,477,160	17,214,023	434,518.32	39.62	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,735,241	0	5,735,241	149,463.00	38.37	4.00
5.00	Subtotal wage-related costs (see inst.)	10,962,337	0	10,962,337	0.00	63.68	5.00
6.00	Total (sum of lines 3 thru 5)	28,434,441	5,477,160	33,911,601	583,981.32	58.07	6.00
7.00	Total overhead cost (see instructions)	6,141,398	3,961,010	10,102,408	266,776.70	37.87	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/28/2024 1:29 pm
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		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	497,375	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	1,542,622	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	4,441	6.00
7.00	Employee Managed Care Program Administration Fees	82,415	7.00
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,601,791	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,010,048	9.00
10.00	Dental, Hearing and Vision Plan	124,137	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	23,650	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	86,865	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	13,619	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	1,870,266	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
<b>OTHER</b>			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	14,609	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	56,319	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,928,157	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part V Date/Time Prepared: 5/28/2024 1:29 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	8,928,157	1.00
2.00	Hospital	0	8,928,157	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/28/2024 1:29 pm
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				1.00			
<b>PART I - HOSPITAL AND HOSPITAL COMPLEX DATA</b>							
Uncompensated and Indigent Care Cost-to-Charge Ratio							
1.00	Cost to charge ratio (see instructions)			0.186001	1.00		
Medicaid (see instructions for each line)							
2.00	Net revenue from Medicaid			3,012,063	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00		
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			Y	4.00		
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00		
6.00	Medicaid charges			24,551,599	6.00		
7.00	Medicaid cost (line 1 times line 6)			4,566,622	7.00		
8.00	Difference between net revenue and costs for Medicaid program (see instructions)			1,554,559	8.00		
Children's Health Insurance Program (CHIP) (see instructions for each line)							
9.00	Net revenue from stand-alone CHIP			16,380	9.00		
10.00	Stand-alone CHIP charges			53,730	10.00		
11.00	Stand-alone CHIP cost (line 1 times line 10)			9,994	11.00		
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)			0	12.00		
Other state or local government indigent care program (see instructions for each line)							
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			4,897,731	13.00		
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			33,856,127	14.00		
15.00	State or local indigent care program cost (line 1 times line 14)			6,297,273	15.00		
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)			1,399,542	16.00		
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)							
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00		
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00		
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			2,954,101	19.00		
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
				1.00	2.00	3.00	
Uncompensated care cost (see instructions for each line)							
20.00	Charity care charges and uninsured discounts (see instructions)			4,256,803	1,630,138	5,886,941	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)			791,770	1,463,486	2,255,256	21.00
22.00	Payments received from patients for amounts previously written off as charity care			0	0	0	22.00
23.00	Cost of charity care (see instructions)			791,770	1,463,486	2,255,256	23.00
				1.00			
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N			24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit					0	25.00
25.01	Charges for insured patients' liability (see instructions)					204,733	25.01
26.00	Bad debt amount (see instructions)					4,368,107	26.00
27.00	Medicare reimbursable bad debts (see instructions)					34,575	27.00
27.01	Medicare allowable bad debts (see instructions)					53,193	27.01
28.00	Non-Medicare bad debt amount (see instructions)					4,314,914	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)					821,196	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)					3,076,452	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)					6,030,553	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/28/2024 1:29 pm
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				1.00	
<b>PART II - HOSPITAL DATA</b>					
<b>Uncompensated and Indigent Care Cost-to-Charge Ratio</b>					
1.00	Cost to charge ratio (see instructions)			0.186001	1.00
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid				2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid				5.00
6.00	Medicaid charges				6.00
7.00	Medicaid cost (line 1 times line 6)				7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)				8.00
<b>Children's Health Insurance Program (CHIP) (see instructions for each line)</b>					
9.00	Net revenue from stand-alone CHIP				9.00
10.00	Stand-alone CHIP charges				10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)				12.00
<b>Other state or local government indigent care program (see instructions for each line)</b>					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)				13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)				14.00
15.00	State or local indigent care program cost (line 1 times line 14)				15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)				16.00
<b>Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)</b>					
17.00	Private grants, donations, or endowment income restricted to funding charity care				17.00
18.00	Government grants, appropriations or transfers for support of hospital operations				18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)				19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
<b>Uncompensated care cost (see instructions for each line)</b>					
20.00	Charity care charges and uninsured discounts (see instructions)	4,256,803	1,630,138	5,886,941	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	791,770	1,463,486	2,255,256	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	791,770	1,463,486	2,255,256	23.00
				1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
25.01	Charges for insured patients' liability (see instructions)			204,733	25.01
26.00	Bad debt amount (see instructions)			4,368,107	26.00
27.00	Medicare reimbursable bad debts (see instructions)			34,575	27.00
27.01	Medicare allowable bad debts (see instructions)			53,193	27.01
28.00	Non-Medicare bad debt amount (see instructions)			4,314,914	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			821,196	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			3,076,452	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			3,076,452	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0045		Period: From 01/01/2023 To 12/31/2023		Worksheet A	
Date/Time Prepared: 5/28/2024 1:29 pm							
Cost Center	Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		1,704,690	1,704,690	28,537	1,733,227	1.00
2.00	00200		0	0	0	0	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	2,289,632	6,508,098	8,797,730	-2,289,632	6,508,098	4.00
5.00	00500	822,438	26,358,859	27,181,297	110,050	27,291,347	5.00
7.00	00700	595,703	1,268,253	1,863,956	79,710	1,943,666	7.00
8.00	00800	0	0	0	0	0	8.00
9.00	00900	811,672	466,592	1,278,264	108,609	1,386,873	9.00
10.00	01000	540,818	458,911	999,729	-450,256	549,473	10.00
10.01	01001	0	0	0	0	0	10.01
11.00	01100	0	0	0	522,622	522,622	11.00
13.00	01300	433,909	14,817	448,726	58,061	506,787	13.00
14.00	01400	79,291	104,926	184,217	10,610	194,827	14.00
15.00	01500	567,935	63,811	631,746	75,995	707,741	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	6,458	6,458	0	6,458	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,464,919	290,787	2,755,706	-379,907	2,375,799	30.00
31.00	03100	951,712	213,073	1,164,785	127,348	1,292,133	31.00
43.00	04300	0	0	0	140,939	140,939	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1,756,652	1,726,278	3,482,930	235,056	3,717,986	50.00
52.00	05200	0	0	0	568,796	568,796	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	1,888,811	772,092	2,660,903	252,740	2,913,643	54.00
60.00	06000	0	3,462,776	3,462,776	0	3,462,776	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	697,248	184,005	881,253	93,298	974,551	65.00
66.00	06600	1,322,372	14,811	1,337,183	176,945	1,514,128	66.00
66.01	06601	149,081	19,974	169,055	19,948	189,003	66.01
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	84,345	1,367	85,712	11,286	96,998	69.00
70.00	07000	108,960	14,916	123,876	14,580	138,456	70.00
71.00	07100	0	1,839,911	1,839,911	0	1,839,911	71.00
72.00	07200	0	762,082	762,082	0	762,082	72.00
73.00	07300	0	3,221,013	3,221,013	0	3,221,013	73.00
76.98	07698	0	0	0	0	0	76.98
77.00	07700	0	0	0	0	0	77.00
78.00	07800	0	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	515	1,166	1,681	69	1,750	90.00
90.01	09001	159,530	1,553	161,083	21,347	182,430	90.01
91.00	09100	1,746,561	217,826	1,964,387	233,705	2,198,092	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	1,928,730	388,088	2,316,818	258,081	2,574,899	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
102.00	10200	0	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	0	28,537	28,537	-28,537	0	113.00
116.00	11600	0	0	0	0	0	116.00
118.00		19,400,834	50,115,670	69,516,504	0	69,516,504	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	582,062	582,062	0	582,062	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
192.04	19204	0	0	0	0	0	192.04
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	34,824	34,824	0	34,824	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00		19,400,834	50,732,556	70,133,390	0	70,133,390	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Prepared: 5/28/2024 1:29 pm
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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	0	1,733,227	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,508,098	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-11,684,935	15,606,412	5.00
7.00	00700	OPERATION OF PLANT	-1,110	1,942,556	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	0	1,386,873	9.00
10.00	01000	DIETARY	-344,710	204,763	10.00
10.01	01001	SNACK BAR	0	0	10.01
11.00	01100	CAFETERIA	0	522,622	11.00
13.00	01300	NURSING ADMINISTRATION	0	506,787	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	194,827	14.00
15.00	01500	PHARMACY	-130	707,611	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	6,458	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-159,000	2,216,799	30.00
31.00	03100	INTENSIVE CARE UNIT	-159,000	1,133,133	31.00
43.00	04300	NURSERY	0	140,939	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-678,605	3,039,381	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	568,796	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-59,945	2,853,698	54.00
60.00	06000	LABORATORY	0	3,462,776	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	974,551	65.00
66.00	06600	PHYSICAL THERAPY	-2,800	1,511,328	66.00
66.01	06601	CARDIAC REHAB	-5,260	183,743	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	96,998	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	138,456	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,839,911	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	762,082	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,221,013	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	1,750	90.00
90.01	09001	ATU CLINIC	0	182,430	90.01
91.00	09100	EMERGENCY	0	2,198,092	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	-11,167	2,563,732	95.00
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,106,662	56,409,842	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	582,062	192.01
192.02	19202	PHARMACARE	0	0	192.02
192.03	19203	OUTSOURCED DIETICIAN	0	0	192.03
192.04	19204	BUSINESS HEALTH	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	-6,664	28,160	194.00
194.01	07951	ADULT DAY CARE	0	0	194.01
194.02	07952	FOUNDATION	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,113,326	57,020,064	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
<b>A - CAFETERIA RECLASS</b>						
1.00	CAFETERIA	11.00	282,332	240,290	1.00	
	O		282,332	240,290		
<b>B - LABOR DELIVERY NURSERY</b>						
1.00	NURSERY	43.00	132,283	8,656	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	533,863	34,933	2.00	
	O		666,146	43,589		
<b>D - HOME OFFICE SALARIES RECLASS</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	5,735,241	0	1.00	
	TOTALS		5,735,241	0		
<b>G - INTEREST EXPENSE</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	28,537	1.00	
	O		0	28,537		
<b>H - PTO RECLASS</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	110,050	0	1.00	
2.00	OPERATION OF PLANT	7.00	79,710	0	2.00	
3.00	HOUSEKEEPING	9.00	108,609	0	3.00	
4.00	DIETARY	10.00	72,366	0	4.00	
5.00	NURSING ADMINISTRATION	13.00	58,061	0	5.00	
6.00	CENTRAL SERVICES & SUPPLY	14.00	10,610	0	6.00	
7.00	PHARMACY	15.00	75,995	0	7.00	
8.00	ADULTS & PEDIATRICS	30.00	329,828	0	8.00	
9.00	INTENSIVE CARE UNIT	31.00	127,348	0	9.00	
10.00	OPERATING ROOM	50.00	235,056	0	10.00	
11.00	RADIOLOGY-DIAGNOSTIC	54.00	252,740	0	11.00	
12.00	RESPIRATORY THERAPY	65.00	93,298	0	12.00	
13.00	PHYSICAL THERAPY	66.00	176,945	0	13.00	
14.00	CARDIAC REHAB	66.01	19,948	0	14.00	
15.00	ELECTROCARDIOLOGY	69.00	11,286	0	15.00	
16.00	ELECTROENCEPHALOGRAPHY	70.00	14,580	0	16.00	
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	0	17.00	
18.00	CLINIC	90.00	69	0	18.00	
19.00	ATU CLINIC	90.01	21,347	0	19.00	
20.00	EMERGENCY	91.00	233,705	0	20.00	
21.00	AMBULANCE SERVICES	95.00	258,081	0	21.00	
	O		2,289,632	0		
500.00	Grand Total: Increases		8,973,351	312,416	500.00	

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	<b>A - CAFETERIA RECLASS</b>						
1.00	DIETARY	10.00	282,332	240,290	0		1.00
	0		282,332	240,290			
	<b>B - LABOR DELIVERY NURSERY</b>						
1.00	ADULTS & PEDIATRICS	30.00	666,146	43,589	0		1.00
2.00	0	0.00	0	0	0		2.00
	0		666,146	43,589			
	<b>D - HOME OFFICE SALARIES RECLASS</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,735,241	0		1.00
	TOTALS		0	5,735,241			
	<b>G - INTEREST EXPENSE</b>						
1.00	INTEREST EXPENSE	113.00	0	28,537	11		1.00
	0		0	28,537			
	<b>H - PTO RECLASS</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2,289,632	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
	0		2,289,632	0	0		
500.00	Grand Total: Decreases		3,238,110	6,047,657			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0045

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/28/2024 1:29 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	4,509,748	0	0	0	0	1.00
2.00	Land Improvements	694,543	475,250	0	475,250	0	2.00
3.00	Buildings and Fixtures	24,542,806	327,780	0	327,780	0	3.00
4.00	Building Improvements	8,000	0	0	0	0	4.00
5.00	Fixed Equipment	1,873,668	247,095	0	247,095	35,219	5.00
6.00	Movable Equipment	6,546,090	1,327,288	0	1,327,288	157,000	6.00
7.00	HIT designated Assets	326,671	110,940	0	110,940	0	7.00
8.00	Subtotal (sum of lines 1-7)	38,501,526	2,488,353	0	2,488,353	192,219	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	38,501,526	2,488,353	0	2,488,353	192,219	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	4,509,748	0				1.00
2.00	Land Improvements	1,169,793	0				2.00
3.00	Buildings and Fixtures	24,870,586	0				3.00
4.00	Building Improvements	8,000	8,000				4.00
5.00	Fixed Equipment	2,085,544	5,790				5.00
6.00	Movable Equipment	7,716,378	1,638,877				6.00
7.00	HIT designated Assets	437,611	0				7.00
8.00	Subtotal (sum of lines 1-7)	40,797,660	1,652,667				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	40,797,660	1,652,667				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0045

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/28/2024 1:29 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,704,690	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)	1,704,690	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,704,690				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,704,690				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0045

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/28/2024 1:29 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	32,643,671	0	32,643,671	0.808811	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,716,378	0	7,716,378	0.191189	0	2.00
3.00	Total (sum of lines 1-2)	40,360,049	0	40,360,049	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,704,690	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	1,704,690	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	28,537	0	0	0	1,733,227	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	28,537	0	0	0	1,733,227	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0045

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

Worksheet A-8

Date/Time Prepared:  
5/28/2024 1:29 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.	
			3.00	4.00	5.00	
1.00	2.00	3.00	4.00	5.00		
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			OCAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			OCAP 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	-1,067,717			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	-7,849,797			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	0	OCAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	0	OMEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	ORESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	OPHYSICAL 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	OCAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	OCAP 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	OADULTS & PEDIATRICS	30.00		30.99

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
			Cost Center		Line #		
			1.00	2.00	3.00		
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 OTHER INCOME	B	-33,850		ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01 OTHER INCOME	B	-1,110		OPERATION OF PLANT	7.00	0	33.01
33.02 OTHER INCOME	B	-344,710		DIETARY	10.00	0	33.02
33.03 OTHER INCOME	B	-2,800		PHYSICAL THERAPY	66.00	0	33.03
33.04 OTHER INCOME	B	-5,260		CARDIAC REHAB	66.01	0	33.04
33.05 INTEREST				CAP REL COSTS-BLDG & FIXT	1.00	0	33.05
33.06 EE DRUGS	B	-130		PHARMACY	15.00	0	33.06
33.07 INTERUNIT EXPENSE		0			0.00	0	33.07
33.08 LOBBYING	A	-1,150		ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09 MARKETING	A	-200		ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10 MARKETING	A	-6,664		OTHER NONREIMBURSABLE COST CENT	194.00	0	33.10
33.11 NON-ALLOWABLE	A			EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12 RECRUITMENT	A			ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13 HAF	A	-3,799,938		ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14 OTHER ADJUSTMENTS (SPECIFY (3))		0			0.00	0	33.14
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,113,326					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: 15-0045  
 Period: From 01/01/2023 To 12/31/2023  
 Worksheet A-8-1  
 Date/Time Prepared: 5/28/2024 1:29 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	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	14,492,584	12,830,430 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY SUBSIDY (PPG)	0	8,961,708 2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE ELIMINATION	0	550,243 3.00
4.00	0.00			0	0 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			14,492,584	22,342,381 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.

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

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

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

6.00	B		0.00	PARKVIEW HEALTH	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					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: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Date/Time Prepared: 5/28/2024 1:29 pm
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	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	1,662,154	0		1.00
2.00	-8,961,708	0		2.00
3.00	-550,243	0		3.00
4.00	0	0		4.00
5.00	-7,849,797			5.00

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

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

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

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

6.00	HEALTH SYSTEM		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: 15-0045

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

Worksheet A-8-2

Date/Time Prepared:  
5/28/2024 1:29 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	159,000	159,000	0	197,500	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	159,000	159,000	0	197,500	0	2.00
3.00	50.00	OPERATING ROOM	678,605	678,605	0	197,500	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	59,945	59,945	0	271,900	0	4.00
5.00	95.00	AMBULANCE SERVICES	11,167	11,167	0	197,500	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			1,067,717	1,067,717	0		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	95.00	AMBULANCE SERVICES	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			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	159,000		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	159,000		2.00
3.00	50.00	OPERATING ROOM	0	0	0	678,605		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	59,945		4.00
5.00	95.00	AMBULANCE SERVICES	0	0	0	11,167		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	0	0	1,067,717		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0045

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/28/2024 1:29 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,733,227	1,733,227			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	6,508,098	0	0	6,508,098	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	15,606,412	89,967	0	1,726,365	17,422,744 5.00
7.00 00700	OPERATION OF PLANT	1,942,556	765,310	0	174,875	2,882,741 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	11,395	0	0	11,395 8.00
9.00 00900	HOUSEKEEPING	1,386,873	18,219	0	238,275	1,643,367 9.00
10.00 01000	DIETARY	204,763	9,563	0	85,663	299,989 10.00
10.01 01001	SNACK BAR	0	0	0	0	0 10.01
11.00 01100	CAFETERIA	522,622	29,509	0	73,100	625,231 11.00
13.00 01300	NURSING ADMINISTRATION	506,787	10,116	0	127,378	644,281 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	194,827	12,015	0	23,277	230,119 14.00
15.00 01500	PHARMACY	707,611	11,051	0	166,723	885,385 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0 16.00
17.00 01700	SOCIAL SERVICE	6,458	1,565	0	0	8,023 17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	2,216,799	111,908	0	551,127	2,879,834 30.00
31.00 03100	INTENSIVE CARE UNIT	1,133,133	47,517	0	279,385	1,460,035 31.00
43.00 04300	NURSERY	140,939	8,513	0	34,250	183,702 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	3,039,381	169,312	0	515,683	3,724,376 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	568,796	98,747	0	138,225	805,768 52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,853,698	88,898	0	554,480	3,497,076 54.00
60.00 06000	LABORATORY	3,462,776	39,978	0	0	3,502,754 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00 06500	RESPIRATORY THERAPY	974,551	10,422	0	204,684	1,189,657 65.00
66.00 06600	PHYSICAL THERAPY	1,511,328	49,779	0	388,196	1,949,303 66.00
66.01 06601	CARDIAC REHAB	183,743	26,197	0	43,764	253,704 66.01
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	96,998	0	0	24,760	121,758 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	138,456	0	0	31,986	170,442 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	1,839,911	0	0	0	1,839,911 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	762,082	0	0	0	762,082 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	3,221,013	0	0	0	3,221,013 73.00
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0 77.00
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0 78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	1,750	0	0	151	1,901 90.00
90.01 09001	ATU CLINIC	182,430	73,447	0	46,832	302,709 90.01
91.00 09100	EMERGENCY	2,198,092	0	0	512,721	2,710,813 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	2,563,732	1,117	0	566,198	3,131,047 95.00
99.10 09910	CORF	0	0	0	0	0 99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0 102.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0 113.00
116.00 11600	HOSPICE	0	0	0	0	0 116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	56,409,842	1,684,545	0	6,508,098	56,361,160 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0 190.00
191.00 19100	RESEARCH	0	0	0	0	0 191.00
192.00 19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0 192.00
192.01 19201	DEKALB MEDICAL SERVICES	582,062	48,682	0	0	630,744 192.01
192.02 19202	PHARMACARE	0	0	0	0	0 192.02
192.03 19203	OUTSOURCED DIETICIAN	0	0	0	0	0 192.03
192.04 19204	BUSINESS HEALTH	0	0	0	0	0 192.04
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENT	28,160	0	0	0	28,160 194.00
194.01 07951	ADULT DAY CARE	0	0	0	0	0 194.01
194.02 07952	FOUNDATION	0	0	0	0	0 194.02
200.00	Cross Foot Adjustments	0	0	0	0	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	57,020,064	1,733,227	0	6,508,098	57,020,064 202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0045		Period: From 01/01/2023 To 12/31/2023		Worksheet B Part I Date/Time Prepared: 5/28/2024 1:29 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	17,422,744					5.00
7.00	00700	OPERATION OF PLANT	1,268,400	4,151,141				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,014	53,878	70,287			8.00
9.00	00900	HOUSEKEEPING	723,078	86,142	0	2,452,587		9.00
10.00	01000	DIETARY	131,995	45,214	0	27,646	504,844	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	275,100	139,524	0	85,311	0	11.00
13.00	01300	NURSING ADMINISTRATION	283,482	47,831	0	29,246	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	101,252	56,811	0	34,737	0	14.00
15.00	01500	PHARMACY	389,568	52,254	0	31,950	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	3,530	7,400	0	4,525	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,267,121	529,125	12,831	323,531	344,965	30.00
31.00	03100	INTENSIVE CARE UNIT	642,412	224,673	4,890	137,375	159,879	31.00
43.00	04300	NURSERY	80,829	40,251	1,750	24,611	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,638,724	800,545	13,322	489,494	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	354,536	466,898	7,062	285,484	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,538,706	420,330	10,243	257,010	0	54.00
60.00	06000	LABORATORY	1,541,205	189,025	0	115,578	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	523,447	49,275	0	30,129	0	65.00
66.00	06600	PHYSICAL THERAPY	857,689	235,367	805	143,914	0	66.00
66.01	06601	CARDIAC REHAB	111,629	123,865	0	75,737	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	53,573	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	74,994	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	809,557	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	335,315	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,417,239	0	0	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	836	0	0	0	0	90.00
90.01	09001	ATU CLINIC	133,191	347,275	0	212,340	0	90.01
91.00	09100	EMERGENCY	1,192,752	0	17,331	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	1,377,654	5,280	1,963	3,228	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,132,828	3,920,963	70,197	2,311,846	504,844	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	277,526	230,178	0	140,741	0	192.01
192.02	19202	PHARMACARE	0	0	0	0	0	192.02
192.03	19203	OUTSOURCED DIETICIAN	0	0	0	0	0	192.03
192.04	19204	BUSINESS HEALTH	0	0	90	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	12,390	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
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)	17,422,744	4,151,141	70,287	2,452,587	504,844	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Prepared: 5/28/2024 1:29 pm
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Cost Center Description		SNACK BAR	CAFETERIA	NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY		
		10.01	11.00	13.00	14.00	15.00		
<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	
10.01	01001	0					10.01	
11.00	01100	0	1,125,166				11.00	
13.00	01300	0	25,659	1,030,499			13.00	
14.00	01400	0	12,365	21,859	457,143		14.00	
15.00	01500	0	26,646	47,178	0	1,432,981	15.00	
16.00	01600	0	0	0	0	0	16.00	
17.00	01700	0	0	0	0	0	17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	0	152,097	269,304	0	0	30.00	
31.00	03100	0	76,571	135,553	0	0	31.00	
43.00	04300	0	8,418	14,856	0	0	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	0	136,829	242,324	0	0	50.00	
52.00	05200	0	33,844	59,963	0	0	52.00	
53.00	05300	0	0	0	0	0	53.00	
54.00	05400	0	141,821	0	0	0	54.00	
60.00	06000	0	0	0	0	0	60.00	
60.01	06001	0	0	0	0	0	60.01	
65.00	06500	0	62,464	0	0	0	65.00	
66.00	06600	0	99,095	0	0	0	66.00	
66.01	06601	0	12,771	0	0	0	66.01	
67.00	06700	0	0	0	0	0	67.00	
68.00	06800	0	0	0	0	0	68.00	
69.00	06900	0	7,024	0	0	0	69.00	
70.00	07000	0	8,650	0	0	0	70.00	
71.00	07100	0	0	0	457,143	0	71.00	
72.00	07200	0	0	0	0	0	72.00	
73.00	07300	0	10,565	0	0	1,432,981	73.00	
76.98	07698	0	0	0	0	0	76.98	
77.00	07700	0	0	0	0	0	77.00	
78.00	07800	0	0	0	0	0	78.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	0	290	504	0	0	90.00	
90.01	09001	0	0	0	0	0	90.01	
91.00	09100	0	134,971	238,958	0	0	91.00	
92.00	09200	0	0	0	0	0	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	0	175,086	0	0	0	95.00	
99.10	09910	0	0	0	0	0	99.10	
101.00	10100	0	0	0	0	0	101.00	
102.00	10200	0	0	0	0	0	102.00	
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	0	0	0	0	0	113.00	
116.00	11600	0	0	0	0	0	116.00	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)						0	1,125,166
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	0	0	0	0	0	190.00	
191.00	19100	0	0	0	0	0	191.00	
192.00	19200	0	0	0	0	0	192.00	
192.01	19201	0	0	0	0	0	192.01	
192.02	19202	0	0	0	0	0	192.02	
192.03	19203	0	0	0	0	0	192.03	
192.04	19204	0	0	0	0	0	192.04	
193.00	19300	0	0	0	0	0	193.00	
194.00	07950	0	0	0	0	0	194.00	
194.01	07951	0	0	0	0	0	194.01	
194.02	07952	0	0	0	0	0	194.02	
200.00	Cross Foot Adjustments						0	200.00
201.00	Negative Cost Centers						0	201.00
202.00	TOTAL (sum lines 118 through 201)						0	1,125,166
			1,125,166	1,030,499	457,143	1,432,981	202.00	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0045

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

Worksheet B  
Part I  
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5/28/2024 1:29 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	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
10.01	01001	SNACK BAR					10.01
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0				16.00
17.00	01700	SOCIAL SERVICE	0	23,478			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	23,478	5,802,286	0	5,802,286
31.00	03100	INTENSIVE CARE UNIT	0	0	2,841,388	0	2,841,388
43.00	04300	NURSERY	0	0	354,417	0	354,417
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	7,045,614	0	7,045,614
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	2,013,555	0	2,013,555
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	5,865,186	0	5,865,186
60.00	06000	LABORATORY	0	0	5,348,562	0	5,348,562
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	1,854,972	0	1,854,972
66.00	06600	PHYSICAL THERAPY	0	0	3,286,173	0	3,286,173
66.01	06601	CARDIAC REHAB	0	0	577,706	0	577,706
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	182,355	0	182,355
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	254,086	0	254,086
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	3,106,611	0	3,106,611
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,097,397	0	1,097,397
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	6,081,798	0	6,081,798
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	3,531	0	3,531
90.01	09001	ATU CLINIC	0	0	995,515	0	995,515
91.00	09100	EMERGENCY	0	0	4,294,825	0	4,294,825
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	4,694,258	0	4,694,258
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	23,478	55,700,235	0	55,700,235
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	0	1,279,189	0	1,279,189
192.02	19202	PHARMACARE	0	0	0	0	192.02
192.03	19203	OUTSOURCED DIETICIAN	0	0	0	0	192.03
192.04	19204	BUSINESS HEALTH	0	0	90	0	90
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	40,550	0	40,550
194.01	07951	ADULT DAY CARE	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	23,478	57,020,064	0	57,020,064

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/28/2024 1:29 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT
		BLDG & FIXT	MVBLE EQUIP		
		0	1.00		
<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	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,056,867	89,967	0	5.00
7.00 00700	OPERATION OF PLANT	0	765,310	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	11,395	0	8.00
9.00 00900	HOUSEKEEPING	0	18,219	0	9.00
10.00 01000	DIETARY	0	9,563	0	10.00
10.01 01001	SNACK BAR	0	0	0	10.01
11.00 01100	CAFETERIA	0	29,509	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	10,116	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	12,015	0	14.00
15.00 01500	PHARMACY	0	11,051	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	1,565	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 03000	ADULTS & PEDIATRICS	0	111,908	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0	47,517	0	31.00
43.00 04300	NURSERY	0	8,513	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000	OPERATING ROOM	0	169,312	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	98,747	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	88,898	0	54.00
60.00 06000	LABORATORY	0	39,978	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	10,422	0	65.00
66.00 06600	PHYSICAL THERAPY	0	49,779	0	66.00
66.01 06601	CARDIAC REHAB	0	26,197	0	66.01
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	77.00
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000	CLINIC	0	0	0	90.00
90.01 09001	ATU CLINIC	0	73,447	0	90.01
91.00 09100	EMERGENCY	0	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00 09500	AMBULANCE SERVICES	0	1,117	0	95.00
99.10 09910	CORF	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	101.00
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00 11300	INTEREST EXPENSE				113.00
116.00 11600	HOSPICE	0	0	0	116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1 through 117)	1,056,867	1,684,545	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	191.00
192.00 19200	PHYSICIANS PRIVATE OFFICES	0	0	0	192.00
192.01 19201	DEKALB MEDICAL SERVICES	0	48,682	0	192.01
192.02 19202	PHARMACARE	0	0	0	192.02
192.03 19203	OUTSOURCED DIETICIAN	0	0	0	192.03
192.04 19204	BUSINESS HEALTH	0	0	0	192.04
193.00 19300	NONPAID WORKERS	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	194.00
194.01 07951	ADULT DAY CARE	0	0	0	194.01
194.02 07952	FOUNDATION	0	0	0	194.02
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers		0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1,056,867	1,733,227	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0045		Period: From 01/01/2023 To 12/31/2023		Worksheet B Part II Date/Time Prepared: 5/28/2024 1:29 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	1,146,834					5.00
7.00	00700	OPERATION OF PLANT	83,490	848,800				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	330	11,017	22,742			8.00
9.00	00900	HOUSEKEEPING	47,595	17,614	0	83,428		9.00
10.00	01000	DIETARY	8,688	9,245	0	940	28,436	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	18,108	28,529	0	2,902	0	11.00
13.00	01300	NURSING ADMINISTRATION	18,660	9,780	0	995	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,665	11,616	0	1,182	0	14.00
15.00	01500	PHARMACY	25,643	10,685	0	1,087	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	232	1,513	0	154	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	83,406	108,192	4,152	11,005	19,431	30.00
31.00	03100	INTENSIVE CARE UNIT	42,286	45,940	1,582	4,673	9,005	31.00
43.00	04300	NURSERY	5,320	8,230	566	837	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	107,880	163,689	4,310	16,650	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,337	95,469	2,285	9,711	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	101,282	85,947	3,314	8,743	0	54.00
60.00	06000	LABORATORY	101,447	38,651	0	3,932	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	34,455	10,076	0	1,025	0	65.00
66.00	06600	PHYSICAL THERAPY	56,456	48,126	260	4,895	0	66.00
66.01	06601	CARDIAC REHAB	7,348	25,327	0	2,576	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,526	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,936	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	53,288	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,071	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	93,287	0	0	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	55	0	0	0	0	90.00
90.01	09001	ATU CLINIC	8,767	71,009	0	7,223	0	90.01
91.00	09100	EMERGENCY	78,511	0	5,609	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	90,681	1,080	635	110	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,127,750	801,735	22,713	78,640	28,436	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	18,268	47,065	0	4,788	0	192.01
192.02	19202	PHARMACARE	0	0	0	0	0	192.02
192.03	19203	OUTSOURCED DIETICIAN	0	0	0	0	0	192.03
192.04	19204	BUSINESS HEALTH	0	0	29	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	816	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
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)	1,146,834	848,800	22,742	83,428	28,436	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/28/2024 1:29 pm
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Cost Center Description		SNACK BAR	CAFETERIA	NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY		
		10.01	11.00	13.00	14.00	15.00		
<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	
10.01	01001	0					10.01	
11.00	01100	0	79,048				11.00	
13.00	01300	0	1,803	41,354			13.00	
14.00	01400	0	869	877	33,224		14.00	
15.00	01500	0	1,872	1,893	0	52,231	15.00	
16.00	01600	0	0	0	0	0	16.00	
17.00	01700	0	0	0	0	0	17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	0	10,685	10,809	0	0	30.00	
31.00	03100	0	5,379	5,440	0	0	31.00	
43.00	04300	0	591	596	0	0	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	0	9,613	9,724	0	0	50.00	
52.00	05200	0	2,378	2,406	0	0	52.00	
53.00	05300	0	0	0	0	0	53.00	
54.00	05400	0	9,964	0	0	0	54.00	
60.00	06000	0	0	0	0	0	60.00	
60.01	06001	0	0	0	0	0	60.01	
65.00	06500	0	4,388	0	0	0	65.00	
66.00	06600	0	6,962	0	0	0	66.00	
66.01	06601	0	897	0	0	0	66.01	
67.00	06700	0	0	0	0	0	67.00	
68.00	06800	0	0	0	0	0	68.00	
69.00	06900	0	493	0	0	0	69.00	
70.00	07000	0	608	0	0	0	70.00	
71.00	07100	0	0	0	33,224	0	71.00	
72.00	07200	0	0	0	0	0	72.00	
73.00	07300	0	742	0	0	52,231	73.00	
76.98	07698	0	0	0	0	0	76.98	
77.00	07700	0	0	0	0	0	77.00	
78.00	07800	0	0	0	0	0	78.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	0	20	20	0	0	90.00	
90.01	09001	0	0	0	0	0	90.01	
91.00	09100	0	9,482	9,589	0	0	91.00	
92.00	09200	0	0	0	0	0	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	0	12,302	0	0	0	95.00	
99.10	09910	0	0	0	0	0	99.10	
101.00	10100	0	0	0	0	0	101.00	
102.00	10200	0	0	0	0	0	102.00	
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	0	0	0	0	0	113.00	
116.00	11600	0	0	0	0	0	116.00	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)						0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	0	0	0	0	0	190.00	
191.00	19100	0	0	0	0	0	191.00	
192.00	19200	0	0	0	0	0	192.00	
192.01	19201	0	0	0	0	0	192.01	
192.02	19202	0	0	0	0	0	192.02	
192.03	19203	0	0	0	0	0	192.03	
192.04	19204	0	0	0	0	0	192.04	
193.00	19300	0	0	0	0	0	193.00	
194.00	07950	0	0	0	0	0	194.00	
194.01	07951	0	0	0	0	0	194.01	
194.02	07952	0	0	0	0	0	194.02	
200.00	Cross Foot Adjustments						0	200.00
201.00	Negative Cost Centers						0	201.00
202.00	TOTAL (sum lines 118 through 201)						0	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/28/2024 1:29 pm		
Cost Center	Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	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
10.01	01001	SNACK BAR					10.01
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0				16.00
17.00	01700	SOCIAL SERVICE	0	3,464			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	3,464	363,052	0	363,052
31.00	03100	INTENSIVE CARE UNIT	0	0	161,822	0	161,822
43.00	04300	NURSERY	0	0	24,653	0	24,653
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	481,178	0	481,178
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	234,333	0	234,333
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	298,148	0	298,148
60.00	06000	LABORATORY	0	0	184,008	0	184,008
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	60,366	0	60,366
66.00	06600	PHYSICAL THERAPY	0	0	166,478	0	166,478
66.01	06601	CARDIAC REHAB	0	0	62,345	0	62,345
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	4,019	0	4,019
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	5,544	0	5,544
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	86,512	0	86,512
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	22,071	0	22,071
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	146,260	0	146,260
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	95	0	95
90.01	09001	ATU CLINIC	0	0	160,446	0	160,446
91.00	09100	EMERGENCY	0	0	103,191	0	103,191
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	105,925	0	105,925
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,464	2,670,446	0	2,670,446
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	0	118,803	0	118,803
192.02	19202	PHARMACARE	0	0	0	0	192.02
192.03	19203	OUTSOURCED DIETICIAN	0	0	0	0	192.03
192.04	19204	BUSINESS HEALTH	0	0	29	0	29
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	816	0	816
194.01	07951	ADULT DAY CARE	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,464	2,790,094	0	2,790,094

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0045

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

Worksheet B-1

Date/Time Prepared:  
5/28/2024 1:29 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT	181,612				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		181,612			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	25,136,075		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,427	9,427	6,667,729	-17,422,744	5.00
7.00	00700	OPERATION OF PLANT	80,191	80,191	675,413	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,194	1,194	0	0	8.00
9.00	00900	HOUSEKEEPING	1,909	1,909	920,281	0	9.00
10.00	01000	DIETARY	1,002	1,002	330,852	0	10.00
10.01	01001	SNACK BAR	0	0	0	0	10.01
11.00	01100	CAFETERIA	3,092	3,092	282,332	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,060	1,060	491,970	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,259	1,259	89,901	0	14.00
15.00	01500	PHARMACY	1,158	1,158	643,930	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	164	164	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	11,726	11,726	2,128,601	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,979	4,979	1,079,060	0	31.00
43.00	04300	NURSERY	892	892	132,283	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	17,741	17,741	1,991,708	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,347	10,347	533,863	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,315	9,315	2,141,551	0	54.00
60.00	06000	LABORATORY	4,189	4,189	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,092	1,092	790,546	0	65.00
66.00	06600	PHYSICAL THERAPY	5,216	5,216	1,499,317	0	66.00
66.01	06601	CARDIAC REHAB	2,745	2,745	169,029	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	95,631	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	123,540	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	584	0	90.00
90.01	09001	ATU CLINIC	7,696	7,696	180,877	0	90.01
91.00	09100	EMERGENCY	0	0	1,980,266	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	117	117	2,186,811	0	95.00
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	176,511	176,511	25,136,075	-17,422,744	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	5,101	5,101	0	0	192.01
192.02	19202	PHARMACARE	0	0	0	0	192.02
192.03	19203	OUTSOURCED DIETICIAN	0	0	0	0	192.03
192.04	19204	BUSINESS HEALTH	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0045

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

Worksheet B-1

Date/Time Prepared:  
5/28/2024 1:29 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
202.00 Cost to be allocated (per Wkst. B, Part I)	1,733,227	0	6,508,098		17,422,744	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	9.543571	0.000000	0.258915		0.439998	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			0		1,146,834	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000000		0.028962	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0045

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

Worksheet B-1

Date/Time Prepared:  
5/28/2024 1:29 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	SNACK BAR (MEALS SERVED)	
		7.00	8.00	9.00	10.00	10.01	
<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	91,994				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,194	176,447			8.00
9.00	00900	HOUSEKEEPING	1,909	0	88,891		9.00
10.00	01000	DIETARY	1,002	0	1,002	82,655	10.00
10.01	01001	SNACK BAR	0	0	0	0	10.01
11.00	01100	CAFETERIA	3,092	0	3,092	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,060	0	1,060	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,259	0	1,259	0	14.00
15.00	01500	PHARMACY	1,158	0	1,158	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	164	0	164	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	11,726	32,211	11,726	56,479	0
31.00	03100	INTENSIVE CARE UNIT	4,979	12,277	4,979	26,176	0
43.00	04300	NURSERY	892	4,393	892	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	17,741	33,443	17,741	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,347	17,729	10,347	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,315	25,714	9,315	0	0
60.00	06000	LABORATORY	4,189	0	4,189	0	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,092	0	1,092	0	0
66.00	06600	PHYSICAL THERAPY	5,216	2,021	5,216	0	0
66.01	06601	CARDIAC REHAB	2,745	0	2,745	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	ATU CLINIC	7,696	0	7,696	0	0
91.00	09100	EMERGENCY	0	43,505	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	117	4,928	117	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	86,893	176,221	83,790	82,655	0
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0
192.01	19201	DEKALB MEDICAL SERVICES	5,101	0	5,101	0	0
192.02	19202	PHARMACARE	0	0	0	0	0
192.03	19203	OUTSOURCED DIETICIAN	0	0	0	0	0
192.04	19204	BUSINESS HEALTH	0	226	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0
194.01	07951	ADULT DAY CARE	0	0	0	0	0
194.02	07952	FOUNDATION	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,151,141	70,287	2,452,587	504,844	0
203.00		Unit cost multiplier (Wkst. B, Part I)	45.124041	0.398346	27.590948	6.107846	0.000000

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0045

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

Worksheet B-1

Date/Time Prepared:  
5/28/2024 1:29 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	SNACK BAR (MEALS SERVED)	
		7.00	8.00	9.00	10.00	10.01	
204.00	Cost to be allocated (per Wkst. B, Part II)	848,800	22,742	83,428	28,436	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	9.226689	0.128889	0.938543	0.344032	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0045

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

Worksheet B-1

Date/Time Prepared:  
5/28/2024 1:29 pm

Cost Center Description		CAFETERIA (FTES)	NURSING ADMINISTRATIVE (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
<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
10.01	01001						10.01
11.00	01100	19,382					11.00
13.00	01300	442	208,512				13.00
14.00	01400	213	4,423	100			14.00
15.00	01500	459	9,546	0	100		15.00
16.00	01600	0	0	0	0	299,462,178	16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,620	54,491	0	0	14,114,262	30.00
31.00	03100	1,319	27,428	0	0	4,981,769	31.00
43.00	04300	145	3,006	0	0	665,183	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	2,357	49,032	0	0	53,082,197	50.00
52.00	05200	583	12,133	0	0	2,737,113	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	2,443	0	0	0	52,294,319	54.00
60.00	06000	0	0	0	0	45,744,649	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	1,076	0	0	0	3,450,708	65.00
66.00	06600	1,707	0	0	0	8,990,688	66.00
66.01	06601	220	0	0	0	1,082,197	66.01
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	121	0	0	0	5,110,139	69.00
70.00	07000	149	0	0	0	2,489,748	70.00
71.00	07100	0	0	100	0	6,087,325	71.00
72.00	07200	0	0	0	0	5,182,130	72.00
73.00	07300	182	0	0	100	23,564,103	73.00
76.98	07698	0	0	0	0	0	76.98
77.00	07700	0	0	0	0	0	77.00
78.00	07800	0	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	5	102	0	0	0	90.00
90.01	09001	0	0	0	0	873,966	90.01
91.00	09100	2,325	48,351	0	0	53,972,077	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	3,016	0	0	0	15,039,605	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
102.00	10200	0	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
116.00	11600	0	0	0	0	0	116.00
118.00		19,382	208,512	100	100	299,462,178	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
192.04	19204	0	0	0	0	0	192.04
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00							201.00
202.00		1,125,166	1,030,499	457,143	1,432,981	0	202.00
203.00		58.052110	4.942157	4,571.430000	14,329.810000	0.000000	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0045

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

Worksheet B-1

Date/Time Prepared:  
5/28/2024 1:29 pm

Cost Center Description		CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	79,048	41,354	33,224	52,231	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	4.078423	0.198329	332.240000	522.310000	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0045

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

Worksheet B-1  
Date/Time Prepared:  
5/28/2024 1:29 pm

Cost Center Description		SOCIAL SERVICE (TIME SPENT)	
		17.00	
<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
10.01	01001	SNACK BAR	10.01
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
43.00	04300	NURSERY	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
66.01	06601	CARDIAC REHAB	66.01
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000	CLINIC	90.00
90.01	09001	ATU CLINIC	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
95.00	09500	AMBULANCE SERVICES	95.00
99.10	09910	CORF	99.10
101.00	10100	HOME HEALTH AGENCY	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300	INTEREST EXPENSE	113.00
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	190.00
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
192.01	19201	DEKALB MEDICAL SERVICES	192.01
192.02	19202	PHARMACARE	192.02
192.03	19203	OUTSOURCED DIETICIAN	192.03
192.04	19204	BUSINESS HEALTH	192.04
193.00	19300	NONPAID WORKERS	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	194.00
194.01	07951	ADULT DAY CARE	194.01
194.02	07952	FOUNDATION	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0045

Period:  
From 01/01/2023  
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Worksheet B-1  
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Cost Center Description		SOCIAL SERVICE (TIME SPENT)	
		17.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	34.640000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/28/2024 1:29 pm
			Title XVIII	Hospital	PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
			Total Costs	RCE Disallowance	Total Costs
	1.00	2.00	3.00	4.00	5.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		5,802,286	0	5,802,286
31.00	03100 INTENSIVE CARE UNIT		2,841,388	0	2,841,388
43.00	04300 NURSERY		354,417	0	354,417
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM		7,045,614	0	7,045,614
52.00	05200 DELIVERY ROOM & LABOR ROOM		2,013,555	0	2,013,555
53.00	05300 ANESTHESIOLOGY		0	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC		5,865,186	0	5,865,186
60.00	06000 LABORATORY		5,348,562	0	5,348,562
60.01	06001 BLOOD LABORATORY		0	0	0
65.00	06500 RESPIRATORY THERAPY	0	1,854,972	0	1,854,972
66.00	06600 PHYSICAL THERAPY	0	3,286,173	0	3,286,173
66.01	06601 CARDIAC REHAB	0	577,706	0	577,706
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800 SPEECH PATHOLOGY	0	0	0	0
69.00	06900 ELECTROCARDIOLOGY		182,355	0	182,355
70.00	07000 ELECTROENCEPHALOGRAPHY		254,086	0	254,086
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		3,106,611	0	3,106,611
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		1,097,397	0	1,097,397
73.00	07300 DRUGS CHARGED TO PATIENTS		6,081,798	0	6,081,798
76.98	07698 HYPERBARIC OXYGEN THERAPY		0	0	0
77.00	07700 ALLOGENEIC HSCT ACQUISITION		0	0	0
78.00	07800 CAR T-CELL IMMUNOTHERAPY		0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC		3,531	0	3,531
90.01	09001 ATU CLINIC		995,515	0	995,515
91.00	09100 EMERGENCY		4,294,825	0	4,294,825
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)		2,824,852	0	2,824,852
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES		4,694,258	0	4,694,258
99.10	09910 CORF		0	0	0
101.00	10100 HOME HEALTH AGENCY		0	0	0
102.00	10200 OPIOID TREATMENT PROGRAM		0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300 INTEREST EXPENSE		0	0	0
116.00	11600 HOSPICE		0	0	0
200.00	Subtotal (see instructions)	0	58,525,087	0	58,525,087
201.00	Less Observation Beds		2,824,852		2,824,852
202.00	Total (see instructions)	0	55,700,235	0	55,700,235

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/28/2024 1:29 pm
Title XVIII			Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	9,986,450		9,986,450			30.00
31.00 03100 INTENSIVE CARE UNIT	4,981,769		4,981,769			31.00
43.00 04300 NURSERY	665,183		665,183			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	5,197,921	47,884,276	53,082,197	0.132730	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2,667,089	70,024	2,737,113	0.735649	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	4,984,769	47,309,550	52,294,319	0.112157	0.000000	54.00
60.00 06000 LABORATORY	6,064,926	39,679,723	45,744,649	0.116922	0.000000	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00 06500 RESPIRATORY THERAPY	1,061,758	2,388,950	3,450,708	0.537563	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	651,466	8,339,222	8,990,688	0.365509	0.000000	66.00
66.01 06601 CARDIAC REHAB	0	1,082,197	1,082,197	0.533827	0.000000	66.01
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	544,540	4,565,599	5,110,139	0.035685	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	2,670	2,487,078	2,489,748	0.102053	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	767,790	5,319,535	6,087,325	0.510341	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	602,684	4,579,446	5,182,130	0.211766	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4,363,092	19,201,011	23,564,103	0.258096	0.000000	73.00
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0.000000	0.000000	90.00
90.01 09001 ATU CLINIC	761	873,205	873,966	1.139077	0.000000	90.01
91.00 09100 EMERGENCY	6,014,422	47,957,655	53,972,077	0.079575	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT)	0	4,127,812	4,127,812	0.684346	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	0	15,039,605	15,039,605	0.312126	0.000000	95.00
99.10 09910 CORF	0	0	0			99.10
101.00 10100 HOME HEALTH AGENCY	0	0	0			101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0			102.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPICE	0	0	0			116.00
200.00	Subtotal (see instructions)	48,557,290	250,904,888	299,462,178		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	48,557,290	250,904,888	299,462,178		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/28/2024 1:29 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.132730		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.735649		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.112157		54.00
60.00	06000 LABORATORY	0.116922		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.537563		65.00
66.00	06600 PHYSICAL THERAPY	0.365509		66.00
66.01	06601 CARDIAC REHAB	0.533827		66.01
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.035685		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.102053		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.510341		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.211766		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.258096		73.00
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 ATU CLINIC	1.139077		90.01
91.00	09100 EMERGENCY	0.079575		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0.684346		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.312126		95.00
99.10	09910 CORF			99.10
101.00	10100 HOME HEALTH AGENCY			101.00
102.00	10200 OPIOID TREATMENT PROGRAM			102.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0045

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/28/2024 1:29 pm

		Title XIX		Hospital		Cost		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance			Total Costs
		1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	5,802,286		5,802,286	0	5,802,286	30.00
31.00	03100	INTENSIVE CARE UNIT	2,841,388		2,841,388	0	2,841,388	31.00
43.00	04300	NURSERY	354,417		354,417	0	354,417	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	7,045,614		7,045,614	0	7,045,614	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,013,555		2,013,555	0	2,013,555	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,865,186		5,865,186	0	5,865,186	54.00
60.00	06000	LABORATORY	5,348,562		5,348,562	0	5,348,562	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,854,972	0	1,854,972	0	1,854,972	65.00
66.00	06600	PHYSICAL THERAPY	3,286,173	0	3,286,173	0	3,286,173	66.00
66.01	06601	CARDIAC REHAB	577,706	0	577,706	0	577,706	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	182,355		182,355	0	182,355	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	254,086		254,086	0	254,086	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	3,106,611		3,106,611	0	3,106,611	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,097,397		1,097,397	0	1,097,397	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,081,798		6,081,798	0	6,081,798	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	3,531		3,531	0	3,531	90.00
90.01	09001	ATU CLINIC	995,515		995,515	0	995,515	90.01
91.00	09100	EMERGENCY	4,294,825		4,294,825	0	4,294,825	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	2,824,852		2,824,852	0	2,824,852	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	4,694,258		4,694,258	0	4,694,258	95.00
99.10	09910	CORF	0		0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE	0		0	0	0	113.00
116.00	11600	HOSPICE	0		0	0	0	116.00
200.00		Subtotal (see instructions)	58,525,087	0	58,525,087	0	58,525,087	200.00
201.00		Less Observation Beds	2,824,852		2,824,852		2,824,852	201.00
202.00		Total (see instructions)	55,700,235	0	55,700,235	0	55,700,235	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/28/2024 1:29 pm
		Title XIX	Hospital	Cost

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					
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	9,986,450		9,986,450	30.00
31.00	03100	INTENSIVE CARE UNIT	4,981,769		4,981,769	31.00
43.00	04300	NURSERY	665,183		665,183	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	5,197,921	47,884,276	53,082,197	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,667,089	70,024	2,737,113	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,984,769	47,309,550	52,294,319	54.00
60.00	06000	LABORATORY	6,064,926	39,679,723	45,744,649	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,061,758	2,388,950	3,450,708	65.00
66.00	06600	PHYSICAL THERAPY	651,466	8,339,222	8,990,688	66.00
66.01	06601	CARDIAC REHAB	0	1,082,197	1,082,197	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	544,540	4,565,599	5,110,139	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,670	2,487,078	2,489,748	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	767,790	5,319,535	6,087,325	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	602,684	4,579,446	5,182,130	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,363,092	19,201,011	23,564,103	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	0	0	90.00
90.01	09001	ATU CLINIC	761	873,205	873,966	90.01
91.00	09100	EMERGENCY	6,014,422	47,957,655	53,972,077	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	4,127,812	4,127,812	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	AMBULANCE SERVICES	0	15,039,605	15,039,605	95.00
99.10	09910	CORF	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	0	0	116.00
200.00		Subtotal (see instructions)	48,557,290	250,904,888	299,462,178	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	48,557,290	250,904,888	299,462,178	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/28/2024 1:29 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
66.01	06601	CARDIAC REHAB	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	ATU CLINIC	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
99.10	09910	CORF		99.10
101.00	10100	HOME HEALTH AGENCY		101.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0045		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part I Date/Time Prepared: 5/28/2024 1:29 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
Title XVIII		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	363,052	0	363,052	5,437	66.77	30.00
31.00	INTENSIVE CARE UNIT	161,822		161,822	1,129	143.33	31.00
43.00	NURSERY	24,653		24,653	362	68.10	43.00
200.00	Total (lines 30 through 199)	549,527		549,527	6,928		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	812	54,217				
31.00	INTENSIVE CARE UNIT	157	22,503				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	969	76,720				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prepared: 5/28/2024 1:29 pm
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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	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								
50.00	05000	OPERATING ROOM	481,178	53,082,197	0.009065	938,172	8,505	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	234,333	2,737,113	0.085613	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	298,148	52,294,319	0.005701	1,468,105	8,370	54.00
60.00	06000	LABORATORY	184,008	45,744,649	0.004023	1,618,548	6,511	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	60,366	3,450,708	0.017494	251,423	4,398	65.00
66.00	06600	PHYSICAL THERAPY	166,478	8,990,688	0.018517	234,793	4,348	66.00
66.01	06601	CARDIAC REHAB	62,345	1,082,197	0.057610	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,019	5,110,139	0.000786	181,695	143	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,544	2,489,748	0.002227	2,670	6	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	86,512	6,087,325	0.014212	168,415	2,394	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,071	5,182,130	0.004259	146,050	622	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	146,260	23,564,103	0.006207	1,064,471	6,607	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	95	0	0.000000	0	0	90.00
90.01	09001	ATU CLINIC	160,446	873,966	0.183584	0	0	90.01
91.00	09100	EMERGENCY	103,191	53,972,077	0.001912	1,856,601	3,550	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	176,754	4,127,812	0.042820	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,191,748	268,789,171		7,930,943	45,454	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Prepared: 5/28/2024 1:29 pm
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Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS			1A	1.00	2A	2.00	3.00		
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
INPATIENT ROUTINE SERVICE COST CENTERS			4.00	5.00	6.00	7.00	8.00		
30.00	03000	ADULTS & PEDIATRICS	0	0	5,437	0.00	812	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	1,129	0.00	157	31.00	
43.00	04300	NURSERY		0	362	0.00	0	43.00	
200.00		Total (lines 30 through 199)		0	6,928		969	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
INPATIENT ROUTINE SERVICE COST CENTERS			9.00						
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/28/2024 1:29 pm
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Cost Center Description	Title XVIII			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			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ATU CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/28/2024 1:29 pm
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Cost Center Description	Title XVIII			Hospital	PPS	
	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
	4.00	5.00	6.00	7.00	8.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	53,082,197	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	2,737,113	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	52,294,319	0.000000	54.00
60.00 06000 LABORATORY	0	0	0	45,744,649	0.000000	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00 06500 RESPIRATORY THERAPY	0	0	0	3,450,708	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	8,990,688	0.000000	66.00
66.01 06601 CARDIAC REHAB	0	0	0	1,082,197	0.000000	66.01
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	5,110,139	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	2,489,748	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	6,087,325	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,182,130	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	23,564,103	0.000000	73.00
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0.000000	90.00
90.01 09001 ATU CLINIC	0	0	0	873,966	0.000000	90.01
91.00 09100 EMERGENCY	0	0	0	53,972,077	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT)	0	0	0	4,127,812	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0	0	268,789,171		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/28/2024 1:29 pm
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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									
50.00	05000 OPERATING ROOM	0.000000	938,172	0	5,265,808	0	50.00		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00		
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00		
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	1,468,105	0	4,664,911	0	54.00		
60.00	06000 LABORATORY	0.000000	1,618,548	0	1,310,469	0	60.00		
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01		
65.00	06500 RESPIRATORY THERAPY	0.000000	251,423	0	551,850	0	65.00		
66.00	06600 PHYSICAL THERAPY	0.000000	234,793	0	38,487	0	66.00		
66.01	06601 CARDIAC REHAB	0.000000	0	0	0	0	66.01		
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00		
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00		
69.00	06900 ELECTROCARDIOLOGY	0.000000	181,695	0	281,242	0	69.00		
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	2,670	0	279,260	0	70.00		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000	168,415	0	292,204	0	71.00		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	146,050	0	603,771	0	72.00		
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	1,064,471	0	5,602,024	0	73.00		
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98		
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00		
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00		
OUTPATIENT SERVICE COST CENTERS									
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00		
90.01	09001 ATU CLINIC	0.000000	0	0	0	0	90.01		
91.00	09100 EMERGENCY	0.000000	1,856,601	0	1,485,128	0	91.00		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0.000000	0	0	404,458	0	92.00		
OTHER REIMBURSABLE COST CENTERS									
95.00	09500 AMBULANCE SERVICES						95.00		
200.00	Total (lines 50 through 199)		7,930,943	0	20,779,612	0	200.00		

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/28/2024 1:29 pm
Title XVIII		Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0.132730	5,265,808	0	0	698,931	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.735649	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.112157	4,664,911	0	0	523,202	54.00
60.00 06000 LABORATORY	0.116922	1,310,469	0	0	153,223	60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0.537563	551,850	0	0	296,654	65.00
66.00 06600 PHYSICAL THERAPY	0.365509	38,487	0	0	14,067	66.00
66.01 06601 CARDIAC REHAB	0.533827	0	0	0	0	66.01
67.00 06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.035685	281,242	0	0	10,036	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.102053	279,260	0	0	28,499	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0.510341	292,204	0	0	149,124	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.211766	603,771	0	0	127,858	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.258096	5,602,024	0	0	1,445,860	73.00
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0.000000	0	0	0	0	90.00
90.01 09001 ATU CLINIC	1.139077	0	0	0	0	90.01
91.00 09100 EMERGENCY	0.079575	1,485,128	0	0	118,179	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0.684346	404,458	0	0	276,789	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	0.312126		0	0		95.00
200.00	Subtotal (see instructions)		20,779,612	0	3,842,422	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		20,779,612	0	3,842,422	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/28/2024 1:29 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		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
66.01 06601 CARDIAC REHAB	0	0		66.01
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 ATU CLINIC	0	0		90.01
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 09500 AMBULANCE SERVICES	0			95.00
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 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/28/2024 1:29 pm
	Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0.132730	175,790	0	0	23,333	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.735649	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.112157	237,476	0	0	26,635	54.00
60.00 06000 LABORATORY	0.116922	294,441	0	0	34,427	60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0.537563	22,989	0	0	12,358	65.00
66.00 06600 PHYSICAL THERAPY	0.365509	375,122	0	0	137,110	66.00
66.01 06601 CARDIAC REHAB	0.533827	0	0	0	0	66.01
67.00 06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.035685	19,591	0	0	699	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.102053	33,447	0	0	3,413	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0.510341	9,122	0	0	4,655	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.211766	8,212	0	0	1,739	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.258096	75,819	0	0	19,569	73.00
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0.000000	0	0	0	0	90.00
90.01 09001 ATU CLINIC	1.139077	0	0	0	0	90.01
91.00 09100 EMERGENCY	0.079575	200,672	0	0	15,968	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0.684346	101,413	0	0	69,402	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	0.312126	558,008	0	0		95.00
200.00		Subtotal (see instructions)	1,554,094	0	523,477	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0	0	201.00
202.00		Net Charges (line 200 - line 201)	1,554,094	0	523,477	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/28/2024 1:29 pm
	Title XIX	Hospital	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
66.01 06601 CARDIAC REHAB	0	0		66.01
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 ATU CLINIC	0	0		90.01
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 09500 AMBULANCE SERVICES	0			95.00
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/28/2024 1:29 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)		5,437	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,437	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,790	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)		812	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)		5,802,286	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,802,286	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)		5,802,286	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,067.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		866,558	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)		866,558	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/28/2024 1:29 pm	
Title XVIII			Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	2,841,388	1,129	2,516.73	157	395,127	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)					1,245,509	48.00
48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00 Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					2,507,194	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)					76,720	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					45,454	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					122,174	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,385,020	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
55.01 Permanent adjustment amount per discharge					0.00	55.01
55.02 Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only): for CAH, see instructions					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					2,647	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,067.19	88.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0045		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/28/2024 1:29 pm	
Cost Center Description		Title XVIII		Hospital		PPS	
89.00 Observation bed cost (line 87 x line 88) (see instructions)						1.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)						2,824,852 89.00	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	363,052	5,802,286	0.062571	2,824,852	176,754	90.00
91.00	Nursing Program cost	0	5,802,286	0.000000	2,824,852	0	91.00
92.00	Allied health cost	0	5,802,286	0.000000	2,824,852	0	92.00
93.00	All other Medical Education	0	5,802,286	0.000000	2,824,852	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/28/2024 1:29 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		1,900,606	30.00
31.00	03100	INTENSIVE CARE UNIT		590,822	31.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.132730	938,172	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.735649	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.112157	1,468,105	54.00
60.00	06000	LABORATORY	0.116922	1,618,548	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.537563	251,423	65.00
66.00	06600	PHYSICAL THERAPY	0.365509	234,793	66.00
66.01	06601	CARDIAC REHAB	0.533827	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.035685	181,695	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.102053	2,670	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.510341	168,415	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.211766	146,050	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.258096	1,064,471	73.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	ATU CLINIC	1.139077	0	90.01
91.00	09100	EMERGENCY	0.079575	1,856,601	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.684346	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,930,943	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)		7,930,943	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/28/2024 1:29 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		116,750		30.00
31.00	03100 INTENSIVE CARE UNIT		47,534		31.00
43.00	04300 NURSERY		35,801		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.132730	45,824	6,082	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.735649	25,980	19,112	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.112157	88,974	9,979	54.00
60.00	06000 LABORATORY	0.116922	132,890	15,538	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.537563	31,590	16,982	65.00
66.00	06600 PHYSICAL THERAPY	0.365509	9,401	3,436	66.00
66.01	06601 CARDIAC REHAB	0.533827	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.035685	8,565	306	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.102053	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.510341	6,202	3,165	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.211766	26,711	5,656	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.258096	86,981	22,449	73.00
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 ATU CLINIC	1.139077	0	0	90.01
91.00	09100 EMERGENCY	0.079575	98,214	7,815	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.684346	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		561,332	110,520	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)		561,332		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/28/2024 1:29 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
1.00	DRG Amounts Other than Outlier Payments			0 1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		1,802,890	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		733,566	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		0	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		40.61	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
5.01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)		0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)		0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)		0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
<b>Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment ( sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.57	30.00
31.00	Percentage of Medicaid patient days (see instructions)		20.83	31.00
32.00	Sum of lines 30 and 31		26.40	32.00
33.00	Allowable disproportionate share percentage (see instructions)		10.99	33.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/28/2024 1:29 pm	
		Title XVIII	Hospital	PPS	
				1.00	
34.00	Disproportionate share adjustment (see instructions)			69,690	34.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
<b>Uncompensated Care Payment Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)		6,874,403,459	5,938,006,757	35.00
35.01	Factor 3 (see instructions)		0.000052686	0.000060543	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)		362,185	359,505	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)		270,894	90,367	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		361,261		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>					
40.00	Total Medicare discharges (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		2,967,407		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				<b>Amount</b>	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			2,967,407	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			190,365	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
55.01	Cellular therapy acquisition cost (see instructions)			0	55.01
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			3,157,772	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			3,157,772	61.00
62.00	Deductibles billed to program beneficiaries			421,002	62.00
63.00	Coinsurance billed to program beneficiaries			1,230	63.00
64.00	Allowable bad debts (see instructions)			13,536	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			8,798	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			4,828	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			2,744,338	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)			0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)			0	70.75
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			189	70.93
70.94	HRR adjustment amount (see instructions)			0	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/28/2024 1:29 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	511,639	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		3,256,166	71.00
71.01	Sequestration adjustment (see instructions)		65,123	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		3,120,152	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		70,891	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		82,769	75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
<b>HSP Bonus Payment Amount</b>				
100.00	HSP bonus amount (see instructions)		0	100.00
<b>HVBP Adjustment for HSP Bonus Payment</b>				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
<b>HRR Adjustment for HSP Bonus Payment</b>				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
<b>Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment</b>				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
<b>Cost Reimbursement</b>				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
<b>Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)</b>				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
<b>Adjustment to Medicare Part A Inpatient Reimbursement</b>				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
<b>Comparison of PPS versus Cost Reimbursement</b>				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/28/2024 1:29 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 OPPTS (see instructions)		3,842,422	2.00
3.00	OPPTS or REH payments		3,632,121	3.00
4.00	Outlier payment (see instructions)		17,768	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.864	5.00
6.00	Line 2 times line 5		3,319,853	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		3,649,889	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		731,121	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,918,768	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
28.50	REH facility payment amount (see instructions)			28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)		2,918,768	30.00
31.00	Primary payer payments		3,238	31.00
32.00	Subtotal (line 30 minus line 31)		2,915,530	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)		39,657	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		25,777	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		27,560	36.00
37.00	Subtotal (see instructions)		2,941,307	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)		2,941,307	40.00
40.01	Sequestration adjustment (see instructions)		58,826	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		2,860,443	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)		22,038	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: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/28/2024 1:29 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: 15-0045		Period: From 01/01/2023 To 12/31/2023		Worksheet E-1 Part I Date/Time Prepared: 5/28/2024 1:29 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		3,120,152		2,860,443	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)		3,120,152		2,860,443	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		70,891		22,038	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		3,191,043		2,882,481	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/28/2024 1:29 pm
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (see instructions)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (see instructions)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPSS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/28/2024 1:29 pm	
		Title XIX	Hospital	Cost	
			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		561,332	1,554,094	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)		561,332	1,554,094	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)		561,332	1,554,094	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		561,332	1,554,094	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	0	24.00
25.00	Capital exception payments (see instructions)		0	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	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	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	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

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/28/2024 1:29 pm
Title XVIII			PPS	
			1.00	
<b>TO BE COMPLETED BY CONTRACTOR</b>				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	1.00
2.00	Capital outlier from Wkst. L, Pt. 1, line 2		0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)		0	4.00
5.00	The rate used to calculate the time value of money (see instructions)		0.00	5.00
6.00	Time value of money for operating expenses (see instructions)		0	6.00
7.00	Time value of money for capital related expenses (see instructions)		0	7.00

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

Provider CCN: 15-0045

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

Worksheet G  
Date/Time Prepared:  
5/28/2024 1:29 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	3,053	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	23,513,725	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	10,944,193	0	0	0	6.00
7.00	Inventory	514,725	0	0	0	7.00
8.00	Prepaid expenses	51,339	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	35,027,035	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	4,509,748	0	0	0	12.00
13.00	Land improvements	1,169,793	0	0	0	13.00
14.00	Accumulated depreciation	-176,623	0	0	0	14.00
15.00	Buildings	24,870,586	0	0	0	15.00
16.00	Accumulated depreciation	-4,814,169	0	0	0	16.00
17.00	Leasehold improvements	8,000	0	0	0	17.00
18.00	Accumulated depreciation	-8,000	0	0	0	18.00
19.00	Fixed equipment	23,863	0	0	0	19.00
20.00	Accumulated depreciation	-18,806	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	11,297,102	0	0	0	23.00
24.00	Accumulated depreciation	-4,103,374	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)	32,758,120	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	67,785,155	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	1,416,901	0	0	0	37.00
38.00	Salaries, wages, and fees payable	851,018	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	1,077,910	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,345,829	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	-15,749	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-15,749	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,330,080	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	64,455,075				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	64,455,075	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	67,785,155	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0045

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

Worksheet G-1

Date/Time Prepared:  
5/28/2024 1:29 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		60,715,823			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		3,299,458				2.00
3.00	Total (sum of line 1 and line 2)		64,015,281			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	INTEREST ADD FROM HOME OFFICE	550,243		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		550,243			0	10.00
11.00	Subtotal (line 3 plus line 10)		64,565,524			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	ADJUSTMENT	110,449		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		110,449			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		64,455,075			0	19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	INTEREST ADD FROM HOME OFFICE		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	ADJUSTMENT		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: 15-0045

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/28/2024 1:29 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	5,400,789		5,400,789	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)	5,400,789		5,400,789	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	4,892,633		4,892,633	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)	4,892,633		4,892,633	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	10,293,422		10,293,422	17.00
18.00	Ancillary services	31,876,372	183,146,564	215,022,936	18.00
19.00	Outpatient services	6,372,342	52,676,083	59,048,425	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY	0	0	0	22.00
23.00	AMBULANCE SERVICES	0	15,039,605	15,039,605	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	DIETARY	12,484	45,308	57,792	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	48,554,620	250,907,560	299,462,180	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		70,133,390		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	INTEREST ADD FROM HOME OFFICE	550,243			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)		550,243		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)		70,683,633		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0045

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

Worksheet G-3

Date/Time Prepared:  
5/28/2024 1:29 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	299,462,180	1.00
2.00	Less contractual allowances and discounts on patients' accounts	227,617,417	2.00
3.00	Net patient revenues (line 1 minus line 2)	71,844,763	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	70,683,633	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,161,130	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	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC INCOME	2,138,328	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	2,138,328	25.00
26.00	Total (line 5 plus line 25)	3,299,458	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,299,458	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/28/2024 1:29 pm
		Title XVII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		190,365	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		10.91	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		190,365	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0045	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/28/2024 1:29 pm
		Title XIX	Hospital	Cost
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier			0 1.00
1.01	Model 4 BPCI Capital DRG other than outlier			0 1.01
2.00	Capital DRG outlier payments			0 2.00
2.01	Model 4 BPCI Capital DRG outlier payments			0 2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		0.00	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		0	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00