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: 15-1323	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/24/2024 1:36 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/24/2024 Time: 1:36 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PARKVIEW LAGRANGE HOSPITAL (15-1323) 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	Jeanne Wickens		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Jeanne Wickens			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-4,641	106,977	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	-25,979	82		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	-30,620	107,059	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: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2024 1:36 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 207 NORTH TOWNLINE ROAD	PO Box:			1.00
2.00	City: LAGRANGE	State: IN	Zip Code: 46761-1325	County: LAGRANGE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	PARKVIEW LAGRANGE HOSPITAL	151323	99915	1	05/01/2005	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PARKVIEW LAGRANGE HOSPITAL - SWING	15Z323	99915		05/01/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	2		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2024 1:36 pm

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

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 1:36 pm

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

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

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

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

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

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

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

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		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		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	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2024 1:36 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	58,106	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	Y	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H032	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: WISCONSIN PHYSICIANS SERVICE	Contractor's Number: 08001	141.00
142.00	Street: 10501 CORPORATE DRIVE	PO Box: 5600		142.00
143.00	City: FORT WAYNE	State: IN	Zip Code: 46845	143.00

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 1:36 pm

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

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

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		0.00	169.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2024 1:36 pm

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/18/2024	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/31/2024	Y	03/31/2024	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: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/24/2024 1:36 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SHANNON	ECENBARGER	41.00
42.00	Enter the employer/company name of the cost report preparer.	PARKVIEW HEALTH SYSTEM, INC.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	N/A	SHANNON.ECENBARGER@PARKVIEW.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1323	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/24/2024 1:36 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT 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: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2024 1:36 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	49,872.00	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)		25	9,125	49,872.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	49,872.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				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: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2024 1:36 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	595	25	2,078			1.00
2.00	HMO and other (see instructions)	411	141				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	205	0	592			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	52			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	800	25	2,722			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		6	175			13.00
14.00	Total (see instructions)	800	31	2,897	0.00	112.15	14.00
15.00	CAH visits	4,481	916	30,810			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			105			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	112.15	27.00
28.00	Observation Bed Days		19	1,028			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			1			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	4	117			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: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2024 1:36 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	205	13	889	1.00
2.00	HMO and other (see instructions)			133	66		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	205	13	889	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/24/2024 1:36 pm

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.229481	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	730,364	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	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	11,066,835	6.00
7.00	Medicaid cost (line 1 times line 6)	2,539,628	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	1,809,264	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	86,324	9.00
10.00	Stand-alone CHIP charges	565,622	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	129,800	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	43,476	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)	1,805,298	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	13,125,412	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	3,012,033	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	1,206,735	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)	3,059,475	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)	2,779,581	1,120,373	3,899,954	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	637,861	963,938	1,601,799	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)	637,861	963,938	1,601,799	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)	203,026	25.01
26.00	Bad debt amount (see instructions)	2,822,699	26.00
27.00	Medicare reimbursable bad debts (see instructions)	385,123	27.00
27.01	Medicare allowable bad debts (see instructions)	592,498	27.01
28.00	Non-Medicare bad debt amount (see instructions)	2,230,201	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	719,164	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	2,320,963	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,380,438	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1323	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/24/2024 1:36 pm

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

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)				20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)				21.00
22.00	Payments received from patients for amounts previously written off as charity care				22.00
23.00	Cost of charity care (see instructions)				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?		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		25.00
25.01	Charges for insured patients' liability (see instructions)		25.01
26.00	Bad debt amount (see instructions)		26.00
27.00	Medicare reimbursable bad debts (see instructions)		27.00
27.01	Medicare allowable bad debts (see instructions)		27.01
28.00	Non-Medicare bad debt amount (see instructions)		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/24/2024 1:36 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,059,454	1,059,454	-86,863	972,591	1.00
1.01	00101	EMS WEST STATION		0	0	2,935	2,935	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		22,190	22,190	648,207	670,397	2.00
2.01	00201	EMS WEST STATION EQUIP.		0	0	0	0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,515,402	3,356,747	4,872,149	0	4,872,149	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	496,172	13,672,636	14,168,808	-49,403	14,119,405	5.00
7.00	00700	OPERATION OF PLANT	321,598	736,105	1,057,703	0	1,057,703	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	79,235	79,235	0	79,235	8.00
9.00	00900	HOUSEKEEPING	317,056	50,691	367,747	0	367,747	9.00
10.00	01000	DIETARY	580,153	310,810	890,963	-567,042	323,921	10.00
11.00	01100	CAFETERIA	0	0	0	563,217	563,217	11.00
13.00	01300	NURSING ADMINISTRATION	429,527	983	430,510	0	430,510	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	555,519	64,644	620,163	0	620,163	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,109,337	701,396	2,810,733	-589,175	2,221,558	30.00
43.00	04300	NURSERY	0	0	0	142,081	142,081	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	836,733	1,863,988	2,700,721	0	2,700,721	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	447,094	447,094	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,055,983	598,369	1,654,352	0	1,654,352	54.00
60.00	06000	LABORATORY	0	1,394,238	1,394,238	0	1,394,238	60.00
65.00	06500	RESPIRATORY THERAPY	287,418	448,975	736,393	0	736,393	65.00
66.00	06600	PHYSICAL THERAPY	454,617	7,370	461,987	-220,078	241,909	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	161,788	161,788	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	58,290	58,290	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	472,735	472,735	-276,014	196,721	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	276,014	276,014	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,556,509	1,556,509	0	1,556,509	73.00
76.97	07697	CARDIAC REHABILITATION	51,729	2,766	54,495	0	54,495	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	199,914	73,792	273,706	3,825	277,531	90.01
91.00	09100	EMERGENCY	1,217,099	2,218,321	3,435,420	0	3,435,420	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	24,425	49,756	74,181	0	74,181	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		514,876	514,876	-514,876	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,452,682	29,256,586	39,709,268	0	39,709,268	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,056	19,056	0	19,056	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,217	1,217	0	1,217	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	1,099	1,099	0	1,099	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	381	47,044	47,425	0	47,425	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	10,453,063	29,325,002	39,778,065	0	39,778,065	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/24/2024 1:36 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	418,449	1,391,040		1.00
1.01	00101	EMS WEST STATION	0	2,935		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-229	670,168		2.00
2.01	00201	EMS WEST STATION EQUIP.	0	0		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-24,153	4,847,996		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,832,484	10,286,921		5.00
7.00	00700	OPERATION OF PLANT	-4,127	1,053,576		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	79,235		8.00
9.00	00900	HOUSEKEEPING	0	367,747		9.00
10.00	01000	DIETARY	-125	323,796		10.00
11.00	01100	CAFETERIA	-248,355	314,862		11.00
13.00	01300	NURSING ADMINISTRATION	0	430,510		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	0	620,163		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-507,989	1,713,569		30.00
43.00	04300	NURSERY	0	142,081		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,120,730	1,579,991		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	447,094		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-17,875	1,636,477		54.00
60.00	06000	LABORATORY	0	1,394,238		60.00
65.00	06500	RESPIRATORY THERAPY	0	736,393		65.00
66.00	06600	PHYSICAL THERAPY	-16,406	225,503		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	161,788		67.00
68.00	06800	SPEECH PATHOLOGY	0	58,290		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	196,721		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	276,014		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-28,128	1,528,381		73.00
76.97	07697	CARDIAC REHABILITATION	-823	53,672		76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	277,531		90.01
91.00	09100	EMERGENCY	-529,441	2,905,979		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	74,181		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,912,416	33,796,852		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,056		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,217		192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0		194.00
194.01	07951	FOUNDATION	0	1,099		194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	47,425		194.03
194.04	07954	ER PHYSICIAN	0	0		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,912,416	33,865,649		200.00

RECLASSIFICATIONS | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/24/2024 1:36 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - Rehab Therapy Reclass				
1.00	OCCUPATIONAL THERAPY	67.00	159,207	2,581	1.00
2.00	SPEECH PATHOLOGY	68.00	57,360	930	2.00
	TOTALS		216,567	3,511	
	B - OB Reclass				
1.00	NURSERY	43.00	134,720	7,361	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	423,932	23,162	2.00
	TOTALS		558,652	30,523	
	C - Clinic Dietician				
1.00	LIFEBRIDGE SENIOR CARE	90.01	3,825		1.00
			3,825	0	
	F - Cafeteria Reclass				
1.00	CAFETERIA	11.00	365,893	197,324	1.00
			365,893	197,324	
	G - Insurance Reclass				
1.00	CAP REL COSTS-BLDG & FIXT	1.00		34,266	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00		15,137	2.00
			0	49,403	
	K - Depreciation				
1.00	EMS WEST STATION	1.01		2,935	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00		633,070	2.00
3.00					3.00
			0	636,005	
	M - Interest Reclass				
1.00	CAP REL COSTS-BLDG & FIXT	1.00		514,876	1.00
			0	514,876	
	N - Implantable Medical Supplies				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		276,014	1.00
			0	276,014	
500.00	Grand Total: Increases		1,144,937	1,707,656	500.00

RECLASSIFICATIONS | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/24/2024 1:36 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - Rehab Therapy Reclass						
1.00	PHYSICAL THERAPY	66.00	216,567	3,511	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		216,567	3,511			
	B - OB Reclass						
1.00	ADULTS & PEDIATRICS	30.00	558,652	30,523	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		558,652	30,523			
	C - Clinic Dietician						
1.00	DIETARY	10.00	3,825				1.00
			3,825	0			
	F - Cafeteria Reclass						
1.00	DIETARY	10.00	365,893	197,324			1.00
			365,893	197,324			
	G - Insurance Reclass						
1.00	ADMINISTRATIVE & GENERAL	5.00		49,403	12		1.00
2.00					12		2.00
			0	49,403			
	K - Depreciation						
1.00	CAP REL COSTS-BLDG & FIXT	1.00		636,005	9		1.00
2.00					9		2.00
3.00					9		3.00
			0	636,005			
	M - Interest Reclass						
1.00	INTEREST EXPENSE	113.00		514,876	11		1.00
			0	514,876			
	N - Implantable Medical Supplies						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00		276,014			1.00
			0	276,014			
500.00	Grand Total: Decreases		1,144,937	1,707,656			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/24/2024 1:36 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	320,702	0	0	0	0	1.00
2.00	Land Improvements	2,011,654	0	0	0	0	2.00
3.00	Buildings and Fixtures	13,256,634	43,020	0	43,020	0	3.00
4.00	Building Improvements	15,320	0	0	0	0	4.00
5.00	Fixed Equipment	9,055,505	198,948	0	198,948	0	5.00
6.00	Movable Equipment	10,506,997	720,210	0	720,210	666,884	6.00
7.00	HIT designated Assets	1,824,403	58,206	0	58,206	0	7.00
8.00	Subtotal (sum of lines 1-7)	36,991,215	1,020,384	0	1,020,384	666,884	8.00
9.00	Reconciling Items	281,129	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	36,710,086	1,020,384	0	1,020,384	666,884	10.00

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	320,702	0				1.00
2.00	Land Improvements	2,011,654	707,969				2.00
3.00	Buildings and Fixtures	13,299,654	495,923				3.00
4.00	Building Improvements	15,320	15,320				4.00
5.00	Fixed Equipment	9,254,453	5,142,883				5.00
6.00	Movable Equipment	10,560,323	6,957,977				6.00
7.00	HIT designated Assets	1,882,609	917,416				7.00
8.00	Subtotal (sum of lines 1-7)	37,344,715	14,237,488				8.00
9.00	Reconciling Items	281,129	0				9.00
10.00	Total (line 8 minus line 9)	37,063,586	14,237,488				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/24/2024 1:36 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	1,028,639	22,200	0	0	8,615	1.00
1.01	EMS WEST STATION	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	22,190	0	0	0	2.00
2.01	EMS WEST STATION EQUIP.	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	1,028,639	44,390	0	0	8,615	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	1,059,454	1.00
1.01	EMS WEST STATION	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	22,190	2.00
2.01	EMS WEST STATION EQUIP.	0	0	2.01
3.00	Total (sum of lines 1-2)	0	1,081,644	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 5/24/2024 1:36 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	24,901,783	0	24,901,783	0.710125	0	1.00
1.01	EMS WEST STATION	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	10,841,451	676,453	10,164,998	0.289875	0	2.00
2.01	EMS WEST STATION EQUIP.	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	35,743,234	676,453	35,066,781	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	811,083	22,200	1.00
1.01	EMS WEST STATION	0	0	0	2,935	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	632,841	22,190	2.00
2.01	EMS WEST STATION EQUIP.	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	1,446,859	44,390	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	514,876	34,266	8,615	0	1,391,040	1.00
1.01	EMS WEST STATION	0	0	0	0	2,935	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	15,137	0	0	670,168	2.00
2.01	EMS WEST STATION EQUIP.	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	514,876	49,403	8,615	0	2,064,143	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/24/2024 1:36 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - EMS WEST STATION (chapter 2)		0	EMS WEST STATION	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - EMS WEST STATION EQUIP. (chapter 2)		0	EMS WEST STATION EQUIP.	2.01	0	2.01
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)	A	-3,429	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,161,347			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-1,783,445			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-248,355	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - EMS WEST STATION		0	EMS WEST STATION	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - EMS WEST STATION EQUIP.		0	EMS WEST STATION EQUIP.	2.01	0	27.01
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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/24/2024 1:36 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	Lobbying	A	-5,106	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.02	PPG Admin Med Dir Allocation	A	22,907	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	Miscellaneous Revenue	B	-14,688	OPERATING ROOM	50.00	0	33.03
33.04	HAF Fee Expense Removal	A	-2,056,614	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	Education Revenue	B	-4,800	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	Miscellaneous Revenue	B	-823	CARDIAC REHABILITATION	76.97	0	33.06
33.07	Miscellaneous Revenue	B	-16,406	PHYSICAL THERAPY	66.00	0	33.07
33.08	Pharmacy Employee Rx Purchases	B	-28,128	DRUGS CHARGED TO PATIENTS	73.00	0	33.08
33.09	Miscellaneous Revenue	B	-698	OPERATION OF PLANT	7.00	0	33.09
33.11	CAH HIT ADJ Depr Carryfrwd 2012-2016	A	-10	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.11
33.12	Community Benefit Expense	A	-2,500	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	EMPLOYEE BENEFIT XFER - PHYSICIANS	A	-24,153	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	NON-ALLOWABLE MARKETING EXPENSE	A	-125	DIETARY	10.00	0	33.14
33.15	MEDICARE DEPRECIATION	A	418,449	CAP REL COSTS-BLDG & FIXT	1.00	9	33.15
33.16	MISCELLANEOUS REVENUE	B	-2,926	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	TV DEPRECIATION	A	-219	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,912,416				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: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/24/2024 1:36 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	9,178,243	6,707,416	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	Related Party Subsidy Adj.	0	4,254,272	2.00
3.00	0.00			0	0	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.			9,178,243	10,961,688	5.00

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

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

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

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

6.00	B		0.00	Parkview Health System, Inc.	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: 15-1323	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Date/Time Prepared: 5/24/2024 1:36 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	2,470,827	0		1.00
2.00	-4,254,272	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-1,783,445			5.00

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

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

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

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

6.00	Home Office		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2024 1:36 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	507,989	507,989	0	0	0	1.00
2.00	50.00	OPERATING ROOM	1,106,042	1,106,042	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	17,875	17,875	0	0	0	3.00
4.00	91.00	EMERGENCY	2,031,225	529,441	1,501,784	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,663,131	2,161,347	1,501,784		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	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			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	507,989		1.00
2.00	50.00	OPERATING ROOM	0	0	0	1,106,042		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	17,875		3.00
4.00	91.00	EMERGENCY	0	0	0	529,441		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,161,347		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/24/2024 1:36 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	EMS WEST STATION	MVBLE EQUIP	EMS WEST STATION EQUIP.	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,391,040	1,391,040				1.00
1.01	00101	EMS WEST STATION	2,935	0	2,935			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	670,168			670,168		2.00
2.01	00201	EMS WEST STATION EQUIP.	0			0	0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,847,996	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,286,921	303,137	0	146,042	0	5.00
7.00	00700	OPERATION OF PLANT	1,053,576	74,908	0	36,089	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	79,235	4,283	0	2,063	0	8.00
9.00	00900	HOUSEKEEPING	367,747	15,862	0	7,642	0	9.00
10.00	01000	DIETARY	323,796	56,236	0	27,093	0	10.00
11.00	01100	CAFETERIA	314,862	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	430,510	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	26,713	0	12,870	0	14.00
15.00	01500	PHARMACY	620,163	22,989	0	11,075	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,537	0	2,186	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,713,569	296,822	0	143,002	0	30.00
43.00	04300	NURSERY	142,081	4,469	0	2,153	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,579,991	169,182	0	81,508	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	447,094	21,127	0	10,178	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,636,477	83,846	0	40,395	0	54.00
60.00	06000	LABORATORY	1,394,238	34,754	0	16,744	0	60.00
65.00	06500	RESPIRATORY THERAPY	736,393	10,123	0	4,877	0	65.00
66.00	06600	PHYSICAL THERAPY	225,503	29,354	0	14,142	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	161,788	19,637	0	9,461	0	67.00
68.00	06800	SPEECH PATHOLOGY	58,290	7,076	0	3,409	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	196,721	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	276,014	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,528,381	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	53,672	11,884	0	5,725	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	277,531	15,405	0	7,422	0	90.01
91.00	09100	EMERGENCY	2,905,979	118,516	0	57,098	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	74,181	0	2,935	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,796,852	1,330,860	2,935	641,174	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,056	3,775	0	1,819	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,217	56,405	0	27,175	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	1,099	0	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	47,425	0	0	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	33,865,649	1,391,040	2,935	670,168	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/24/2024 1:36 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,847,996					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	269,135	11,005,235	11,005,235			5.00
7.00	00700	OPERATION OF PLANT	174,442	1,339,015	644,615	1,983,630		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	85,581	41,200	8,387	135,168	8.00
9.00	00900	HOUSEKEEPING	171,978	563,229	271,144	31,061	0	9.00
10.00	01000	DIETARY	114,145	521,270	250,945	110,121	0	10.00
11.00	01100	CAFETERIA	198,469	513,331	247,123	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	232,985	663,495	319,413	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	39,583	19,056	52,309	0	14.00
15.00	01500	PHARMACY	301,326	955,553	460,013	45,016	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,723	3,237	8,884	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	841,132	2,994,525	1,441,594	581,233	45,320	30.00
43.00	04300	NURSERY	73,075	221,778	106,766	8,751	429	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	453,863	2,284,544	1,099,802	331,290	37,532	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	229,950	708,349	341,006	41,370	1,342	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	572,789	2,333,507	1,123,374	164,186	14,227	54.00
60.00	06000	LABORATORY	0	1,445,736	695,992	68,055	0	60.00
65.00	06500	RESPIRATORY THERAPY	155,902	907,295	436,781	19,823	0	65.00
66.00	06600	PHYSICAL THERAPY	129,124	398,123	191,660	57,480	2,996	66.00
67.00	06700	OCCUPATIONAL THERAPY	86,358	277,244	133,468	38,453	0	67.00
68.00	06800	SPEECH PATHOLOGY	31,113	99,888	48,087	13,856	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	196,721	94,703	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	276,014	132,876	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,528,381	735,778	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	28,059	99,340	47,823	23,271	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	110,513	410,871	197,797	30,165	0	90.01
91.00	09100	EMERGENCY	660,182	3,741,775	1,801,330	232,075	33,322	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	13,249	90,365	43,503	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,847,789	33,707,471	10,929,086	1,865,786	135,168	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,650	11,867	7,392	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	84,797	40,822	110,452	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	1,099	529	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	207	47,632	22,931	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,847,996	33,865,649	11,005,235	1,983,630	135,168	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/24/2024 1:36 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
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	865,434					9.00
10.00	01000	DIETARY	49,019	931,355				10.00
11.00	01100	CAFETERIA	0	0	760,454			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	40,603	1,023,511		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,285	0	0	0	134,233	14.00
15.00	01500	PHARMACY	20,039	0	41,506	0	4,370	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,955	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	258,727	931,355	168,278	393,589	1,800	30.00
43.00	04300	NURSERY	3,896	0	12,001	28,102	2,590	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	147,471	0	86,440	202,234	40,758	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,415	0	37,535	87,888	8,101	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	73,086	0	120,005	0	6,899	54.00
60.00	06000	LABORATORY	30,294	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,824	0	33,385	0	6,105	65.00
66.00	06600	PHYSICAL THERAPY	25,587	0	37,626	0	150	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,117	0	13,895	0	100	67.00
68.00	06800	SPEECH PATHOLOGY	6,168	0	4,872	0	36	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	18,725	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	26,253	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	10,359	0	8,030	0	112	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	13,428	0	23,009	0	212	90.01
91.00	09100	EMERGENCY	103,306	0	133,269	311,698	14,006	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	3,743	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	812,976	931,355	760,454	1,023,511	133,960	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,291	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	49,167	0	0	0	52	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	0	0	221	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
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)	865,434	931,355	760,454	1,023,511	134,233	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/24/2024 1:36 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,526,497					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,799				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	6,906	6,823,327	0	6,823,327	30.00
43.00	04300	NURSERY	0	230	384,543	0	384,543	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	752	4,230,823	0	4,230,823	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,244,006	0	1,244,006	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,009	3,840,293	0	3,840,293	54.00
60.00	06000	LABORATORY	0	0	2,240,077	0	2,240,077	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,412,213	0	1,412,213	65.00
66.00	06600	PHYSICAL THERAPY	0	976	714,598	0	714,598	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	182	480,459	0	480,459	67.00
68.00	06800	SPEECH PATHOLOGY	0	93	173,000	0	173,000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	310,149	0	310,149	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	435,143	0	435,143	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,526,497	0	3,790,656	0	3,790,656	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	188,935	0	188,935	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	0	675,482	0	675,482	90.01
91.00	09100	EMERGENCY	0	8,651	6,379,432	0	6,379,432	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	137,611	0	137,611	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,526,497	22,799	33,460,747	0	33,460,747	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	47,200	0	47,200	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	285,290	0	285,290	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	1,628	0	1,628	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	70,784	0	70,784	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,526,497	22,799	33,865,649	0	33,865,649	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/24/2024 1:36 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	EMS WEST STATION	MVBLE EQUIP	EMS WEST STATION EQUIP.	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	855,495	303,137	0	146,042	0	5.00
7.00	00700	OPERATION OF PLANT	0	74,908	0	36,089	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,283	0	2,063	0	8.00
9.00	00900	HOUSEKEEPING	0	15,862	0	7,642	0	9.00
10.00	01000	DIETARY	0	56,236	0	27,093	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	26,713	0	12,870	0	14.00
15.00	01500	PHARMACY	0	22,989	0	11,075	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,537	0	2,186	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	296,822	0	143,002	0	30.00
43.00	04300	NURSERY	0	4,469	0	2,153	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	169,182	0	81,508	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	21,127	0	10,178	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	83,846	0	40,395	0	54.00
60.00	06000	LABORATORY	0	34,754	0	16,744	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	10,123	0	4,877	0	65.00
66.00	06600	PHYSICAL THERAPY	0	29,354	0	14,142	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	19,637	0	9,461	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,076	0	3,409	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	11,884	0	5,725	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	15,405	0	7,422	0	90.01
91.00	09100	EMERGENCY	0	118,516	0	57,098	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	2,935	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	855,495	1,330,860	2,935	641,174	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,775	0	1,819	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	56,405	0	27,175	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	0	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	855,495	1,391,040	2,935	670,168	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/24/2024 1:36 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,304,674	0	1,304,674			5.00
7.00	00700	OPERATION OF PLANT	110,997	0	76,419	187,416		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,346	0	4,884	792	12,022	8.00
9.00	00900	HOUSEKEEPING	23,504	0	32,144	2,935	0	9.00
10.00	01000	DIETARY	83,329	0	29,749	10,404	0	10.00
11.00	01100	CAFETERIA	0	0	29,296	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	37,866	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	39,583	0	2,259	4,942	0	14.00
15.00	01500	PHARMACY	34,064	0	54,534	4,253	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,723	0	384	839	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	439,824	0	170,901	54,915	4,032	30.00
43.00	04300	NURSERY	6,622	0	12,657	827	38	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	250,690	0	130,381	31,301	3,338	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,305	0	40,426	3,909	119	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	124,241	0	133,176	15,513	1,265	54.00
60.00	06000	LABORATORY	51,498	0	82,510	6,430	0	60.00
65.00	06500	RESPIRATORY THERAPY	15,000	0	51,780	1,873	0	65.00
66.00	06600	PHYSICAL THERAPY	43,496	0	22,721	5,431	266	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,098	0	15,823	3,633	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,485	0	5,701	1,309	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	11,227	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	15,752	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	87,226	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	17,609	0	5,669	2,199	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	22,827	0	23,449	2,850	0	90.01
91.00	09100	EMERGENCY	175,614	0	213,556	21,927	2,964	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,935	0	5,157	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,830,464	0	1,295,647	176,282	12,022	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,594	0	1,407	698	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	83,580	0	4,839	10,436	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	63	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	2,718	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,919,638	0	1,304,674	187,416	12,022	202.00

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		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
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	58,583					9.00
10.00	01000	DIETARY	3,318	126,800				10.00
11.00	01100	CAFETERIA	0	0	29,296			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,564	39,430		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,576	0	0	0	48,360	14.00
15.00	01500	PHARMACY	1,356	0	1,599	0	1,574	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	268	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,513	126,800	6,484	15,162	649	30.00
43.00	04300	NURSERY	264	0	462	1,083	933	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,983	0	3,330	7,791	14,683	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,247	0	1,446	3,386	2,919	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,947	0	4,623	0	2,486	54.00
60.00	06000	LABORATORY	2,051	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	597	0	1,286	0	2,199	65.00
66.00	06600	PHYSICAL THERAPY	1,732	0	1,450	0	54	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,159	0	535	0	36	67.00
68.00	06800	SPEECH PATHOLOGY	418	0	188	0	13	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	6,746	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,458	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	701	0	309	0	40	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	909	0	886	0	76	90.01
91.00	09100	EMERGENCY	6,993	0	5,134	12,008	5,046	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	1,349	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	55,032	126,800	29,296	39,430	48,261	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	223	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,328	0	0	0	19	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	0	0	80	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
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)	58,583	126,800	29,296	39,430	48,360	202.00

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		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	97,380					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,214				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,488	838,768	0	838,768	30.00
43.00	04300	NURSERY	0	83	22,969	0	22,969	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	271	451,768	0	451,768	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	84,757	0	84,757	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,805	288,056	0	288,056	54.00
60.00	06000	LABORATORY	0	0	142,489	0	142,489	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	72,735	0	72,735	65.00
66.00	06600	PHYSICAL THERAPY	0	352	75,502	0	75,502	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	66	50,350	0	50,350	67.00
68.00	06800	SPEECH PATHOLOGY	0	34	18,148	0	18,148	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	17,973	0	17,973	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	25,210	0	25,210	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	97,380	0	184,606	0	184,606	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	26,527	0	26,527	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	0	50,997	0	50,997	90.01
91.00	09100	EMERGENCY	0	3,115	446,357	0	446,357	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	9,441	0	9,441	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	97,380	8,214	2,806,653	0	2,806,653	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	7,922	0	7,922	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	102,202	0	102,202	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	63	0	63	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	2,798	0	2,798	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	97,380	8,214	2,919,638	0	2,919,638	202.00

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		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	EMS WEST STATION (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMS WEST STATION EQUIP. (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	2.00	2.01	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	82,172					1.00
1.01	00101	EMS WEST STATION	0	9,760				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			82,172			2.00
2.01	00201	EMS WEST STATION EQUIP.			0	9,760		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	8,937,661	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,907	0	17,907	0	496,172	5.00
7.00	00700	OPERATION OF PLANT	4,425	0	4,425	0	321,598	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	253	0	253	0	0	8.00
9.00	00900	HOUSEKEEPING	937	0	937	0	317,056	9.00
10.00	01000	DIETARY	3,322	0	3,322	0	210,435	10.00
11.00	01100	CAFETERIA	0	0	0	0	365,893	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	429,527	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,578	0	1,578	0	0	14.00
15.00	01500	PHARMACY	1,358	0	1,358	0	555,519	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	268	0	268	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,534	0	17,534	0	1,550,685	30.00
43.00	04300	NURSERY	264	0	264	0	134,720	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,994	0	9,994	0	836,733	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,248	0	1,248	0	423,932	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,953	0	4,953	0	1,055,983	54.00
60.00	06000	LABORATORY	2,053	0	2,053	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	598	0	598	0	287,418	65.00
66.00	06600	PHYSICAL THERAPY	1,734	0	1,734	0	238,050	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,160	0	1,160	0	159,207	67.00
68.00	06800	SPEECH PATHOLOGY	418	0	418	0	57,360	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	702	0	702	0	51,729	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	910	0	910	0	203,739	90.01
91.00	09100	EMERGENCY	7,001	0	7,001	0	1,217,099	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	9,760	0	9,760	24,425	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	78,617	9,760	78,617	9,760	8,937,280	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	223	0	223	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,332	0	3,332	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	0	0	381	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,391,040	2,935	670,168	0	4,847,996	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.928394	0.300717	8.155673	0.000000	0.542423	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

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		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-11,005,235	22,860,414				5.00
7.00	00700	OPERATION OF PLANT	0	1,339,015	59,840			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	85,581	253	133,022		8.00
9.00	00900	HOUSEKEEPING	0	563,229	937	0	58,650	9.00
10.00	01000	DIETARY	0	521,270	3,322	0	3,322	10.00
11.00	01100	CAFETERIA	0	513,331	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	663,495	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	39,583	1,578	0	1,578	14.00
15.00	01500	PHARMACY	0	955,553	1,358	0	1,358	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,723	268	0	268	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,994,525	17,534	44,601	17,534	30.00
43.00	04300	NURSERY	0	221,778	264	422	264	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,284,544	9,994	36,936	9,994	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	708,349	1,248	1,321	1,248	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,333,507	4,953	14,001	4,953	54.00
60.00	06000	LABORATORY	0	1,445,736	2,053	0	2,053	60.00
65.00	06500	RESPIRATORY THERAPY	0	907,295	598	0	598	65.00
66.00	06600	PHYSICAL THERAPY	0	398,123	1,734	2,948	1,734	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	277,244	1,160	0	1,160	67.00
68.00	06800	SPEECH PATHOLOGY	0	99,888	418	0	418	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	196,721	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	276,014	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,528,381	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	99,340	702	0	702	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	410,871	910	0	910	90.01
91.00	09100	EMERGENCY	0	3,741,775	7,001	32,793	7,001	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	90,365	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,005,235	22,702,236	56,285	133,022	55,095	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,650	223	0	223	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	84,797	3,332	0	3,332	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	1,099	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	47,632	0	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
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)		11,005,235	1,983,630	135,168	865,434	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.481410	33.148897	1.016133	14.755908	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		1,304,674	187,416	12,022	58,583	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.057071	3.131952	0.090376	0.998858	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: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 1:36 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
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	6,234					10.00
11.00	01100	CAFETERIA	0	8,428				11.00
13.00	01300	NURSING ADMINISTRATION	0	450	100,851			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,411,256		14.00
15.00	01500	PHARMACY	0	460	0	45,943	27,928	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,234	1,865	38,782	18,929	0	30.00
43.00	04300	NURSERY	0	133	2,769	27,234	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	958	19,927	428,484	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	416	8,660	85,174	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,330	0	72,535	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	370	0	64,184	0	65.00
66.00	06600	PHYSICAL THERAPY	0	417	0	1,575	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	154	0	1,053	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	54	0	379	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	196,865	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	276,014	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	27,928	73.00
76.97	07697	CARDIAC REHABILITATION	0	89	0	1,174	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	255	0	2,231	0	90.01
91.00	09100	EMERGENCY	0	1,477	30,713	147,257	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	39,356	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,234	8,428	100,851	1,408,387	27,928	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	546	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	0	2,323	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
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)	931,355	760,454	1,023,511	134,233	1,526,497	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	149.399262	90.229473	10.148744	0.095116	54.658300	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	126,800	29,296	39,430	48,360	97,380	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	20.340071	3.476032	0.390973	0.034267	3.486823	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: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 1:36 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			16.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	EMS WEST STATION			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
2.01	00201	EMS WEST STATION EQUIP.			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,000		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	3,029		30.00
43.00	04300	NURSERY	101		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	330		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,197		54.00
60.00	06000	LABORATORY	0		60.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	428		66.00
67.00	06700	OCCUPATIONAL THERAPY	80		67.00
68.00	06800	SPEECH PATHOLOGY	41		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.97	07697	CARDIAC REHABILITATION	0		76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		77.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0		90.01
91.00	09100	EMERGENCY	3,794		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,000		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07950	OCCUPATIONAL HEALTH	0		194.00
194.01	07951	FOUNDATION	0		194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0		194.03
194.04	07954	ER PHYSICIAN	0		194.04
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)	22,799		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.279900		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,214		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.821400		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: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 1:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,823,327		6,823,327	0	0	30.00
43.00	04300	NURSERY	384,543		384,543	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,230,823		4,230,823	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,244,006		1,244,006	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,840,293		3,840,293	0	0	54.00
60.00	06000	LABORATORY	2,240,077		2,240,077	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,412,213	0	1,412,213	0	0	65.00
66.00	06600	PHYSICAL THERAPY	714,598	0	714,598	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	480,459	0	480,459	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	173,000	0	173,000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	310,149		310,149	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	435,143		435,143	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,790,656		3,790,656	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	188,935		188,935	0	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	675,482		675,482	0	0	90.01
91.00	09100	EMERGENCY	6,379,432		6,379,432	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,892,959		1,892,959		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	137,611		137,611	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	35,353,706	0	35,353,706	0	0	200.00
201.00		Less Observation Beds	1,892,959		1,892,959		0	201.00
202.00		Total (see instructions)	33,460,747	0	33,460,747	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 1:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,840,810		5,840,810			30.00
43.00	04300	NURSERY	432,503		432,503			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,057,388	20,654,070	25,711,458	0.164550	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,297,590	63,391	1,360,981	0.914051	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	965,611	30,186,498	31,152,109	0.123276	0.000000	54.00
60.00	06000	LABORATORY	2,469,729	16,733,472	19,203,201	0.116651	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,064,872	6,222,246	7,287,118	0.193796	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	207,330	1,418,607	1,625,937	0.439499	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	355,593	341,192	696,785	0.689537	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	64,287	214,622	278,909	0.620274	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	484,337	1,524,988	2,009,325	0.154355	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	160,016	1,519,327	1,679,343	0.259115	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,529,419	11,782,148	14,311,567	0.264867	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	565,101	565,101	0.334338	0.000000	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	5,762	784,377	790,139	0.854890	0.000000	90.01
91.00	09100	EMERGENCY	925,128	29,941,191	30,866,319	0.206679	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	38,292	1,960,770	1,999,062	0.946924	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	21,898,667	123,912,000	145,810,667			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	21,898,667	123,912,000	145,810,667			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 1:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
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
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 1:36 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,823,327		6,823,327	0	6,823,327	30.00
43.00	04300	NURSERY	384,543		384,543	0	384,543	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,230,823		4,230,823	0	4,230,823	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,244,006		1,244,006	0	1,244,006	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,840,293		3,840,293	0	3,840,293	54.00
60.00	06000	LABORATORY	2,240,077		2,240,077	0	2,240,077	60.00
65.00	06500	RESPIRATORY THERAPY	1,412,213	0	1,412,213	0	1,412,213	65.00
66.00	06600	PHYSICAL THERAPY	714,598	0	714,598	0	714,598	66.00
67.00	06700	OCCUPATIONAL THERAPY	480,459	0	480,459	0	480,459	67.00
68.00	06800	SPEECH PATHOLOGY	173,000	0	173,000	0	173,000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	310,149		310,149	0	310,149	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	435,143		435,143	0	435,143	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,790,656		3,790,656	0	3,790,656	73.00
76.97	07697	CARDIAC REHABILITATION	188,935		188,935	0	188,935	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	675,482		675,482	0	675,482	90.01
91.00	09100	EMERGENCY	6,379,432		6,379,432	0	6,379,432	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,892,959		1,892,959		1,892,959	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	137,611		137,611	0	137,611	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	35,353,706	0	35,353,706	0	35,353,706	200.00
201.00		Less Observation Beds	1,892,959		1,892,959		1,892,959	201.00
202.00		Total (see instructions)	33,460,747	0	33,460,747	0	33,460,747	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 1:36 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,840,810		5,840,810			30.00
43.00	04300	NURSERY	432,503		432,503			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,057,388	20,654,070	25,711,458	0.164550	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,297,590	63,391	1,360,981	0.914051	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	965,611	30,186,498	31,152,109	0.123276	0.000000	54.00
60.00	06000	LABORATORY	2,469,729	16,733,472	19,203,201	0.116651	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,064,872	6,222,246	7,287,118	0.193796	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	207,330	1,418,607	1,625,937	0.439499	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	355,593	341,192	696,785	0.689537	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	64,287	214,622	278,909	0.620274	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	484,337	1,524,988	2,009,325	0.154355	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	160,016	1,519,327	1,679,343	0.259115	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,529,419	11,782,148	14,311,567	0.264867	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	565,101	565,101	0.334338	0.000000	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	5,762	784,377	790,139	0.854890	0.000000	90.01
91.00	09100	EMERGENCY	925,128	29,941,191	30,866,319	0.206679	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	38,292	1,960,770	1,999,062	0.946924	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	21,898,667	123,912,000	145,810,667			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	21,898,667	123,912,000	145,810,667			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 1:36 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.164550		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.914051		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123276		54.00
60.00	06000	LABORATORY	0.116651		60.00
65.00	06500	RESPIRATORY THERAPY	0.193796		65.00
66.00	06600	PHYSICAL THERAPY	0.439499		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.689537		67.00
68.00	06800	SPEECH PATHOLOGY	0.620274		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.154355		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.259115		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264867		73.00
76.97	07697	CARDIAC REHABILITATION	0.334338		76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000		77.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0.854890		90.01
91.00	09100	EMERGENCY	0.206679		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.946924		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/24/2024 1:36 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,230,823	451,768	3,779,055	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,244,006	84,757	1,159,249	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,840,293	288,056	3,552,237	0	0	54.00
60.00	06000	LABORATORY	2,240,077	142,489	2,097,588	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,412,213	72,735	1,339,478	0	0	65.00
66.00	06600	PHYSICAL THERAPY	714,598	75,502	639,096	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	480,459	50,350	430,109	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	173,000	18,148	154,852	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	310,149	17,973	292,176	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	435,143	25,210	409,933	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,790,656	184,606	3,606,050	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	188,935	26,527	162,408	0	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	675,482	50,997	624,485	0	0	90.01
91.00	09100	EMERGENCY	6,379,432	446,357	5,933,075	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,892,959	232,696	1,660,263	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	137,611	9,441	128,170	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	28,145,836	2,177,612	25,968,224	0	0	200.00
201.00		Less Observation Beds	1,892,959	232,696	1,660,263	0	0	201.00
202.00		Total (line 200 minus line 201)	26,252,877	1,944,916	24,307,961	0	0	202.00

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

Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/24/2024 1:36 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,230,823	25,711,458	0.164550		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,244,006	1,360,981	0.914051		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,840,293	31,152,109	0.123276		54.00
60.00	06000	LABORATORY	2,240,077	19,203,201	0.116651		60.00
65.00	06500	RESPIRATORY THERAPY	1,412,213	7,287,118	0.193796		65.00
66.00	06600	PHYSICAL THERAPY	714,598	1,625,937	0.439499		66.00
67.00	06700	OCCUPATIONAL THERAPY	480,459	696,785	0.689537		67.00
68.00	06800	SPEECH PATHOLOGY	173,000	278,909	0.620274		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	310,149	2,009,325	0.154355		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	435,143	1,679,343	0.259115		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,790,656	14,311,567	0.264867		73.00
76.97	07697	CARDIAC REHABILITATION	188,935	565,101	0.334338		76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000		77.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0.000000		90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	675,482	790,139	0.854890		90.01
91.00	09100	EMERGENCY	6,379,432	30,866,319	0.206679		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,892,959	1,999,062	0.946924		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	137,611	0	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	28,145,836	139,537,354			200.00
201.00		Less Observation Beds	1,892,959	0			201.00
202.00		Total (line 200 minus line 201)	26,252,877	139,537,354			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/24/2024 1:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	451,768	25,711,458	0.017571	770,379	13,536	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	84,757	1,360,981	0.062276	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	288,056	31,152,109	0.009247	139,271	1,288	54.00
60.00	06000	LABORATORY	142,489	19,203,201	0.007420	427,833	3,175	60.00
65.00	06500	RESPIRATORY THERAPY	72,735	7,287,118	0.009981	331,977	3,313	65.00
66.00	06600	PHYSICAL THERAPY	75,502	1,625,937	0.046436	37,465	1,740	66.00
67.00	06700	OCCUPATIONAL THERAPY	50,350	696,785	0.072260	53,557	3,870	67.00
68.00	06800	SPEECH PATHOLOGY	18,148	278,909	0.065068	18,617	1,211	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,973	2,009,325	0.008945	103,307	924	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,210	1,679,343	0.015012	62,478	938	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	184,606	14,311,567	0.012899	451,842	5,828	73.00
76.97	07697	CARDIAC REHABILITATION	26,527	565,101	0.046942	0	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	50,997	790,139	0.064542	1,892	122	90.01
91.00	09100	EMERGENCY	446,357	30,866,319	0.014461	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	232,696	1,999,062	0.116403	9,324	1,085	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,168,171	139,537,354		2,407,942	37,030	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/24/2024 1:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	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 PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/24/2024 1:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	25,711,458	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,360,981	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	31,152,109	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	19,203,201	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,287,118	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,625,937	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	696,785	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	278,909	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,009,325	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,679,343	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,311,567	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	565,101	0.000000	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	0	0	790,139	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	30,866,319	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,999,062	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	139,537,354		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/24/2024 1:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	770,379	0	0	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	139,271	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	427,833	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	331,977	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	37,465	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	53,557	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	18,617	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	103,307	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	62,478	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	451,842	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0.000000	1,892	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	9,324	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		2,407,942	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/24/2024 1:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.164550	0	2,362,384	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.914051	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123276	0	4,237,981	0	0	54.00
60.00	06000	LABORATORY	0.116651	0	2,566,374	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.193796	0	1,234,584	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.439499	0	274,065	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.689537	0	80,279	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.620274	0	23,773	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.154355	0	130,817	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.259115	0	299,463	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264867	0	3,011,970	944	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.334338	0	201,310	0	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0.854890	0	505,571	0	0	90.01
91.00	09100	EMERGENCY	0.206679	0	3,654,693	816	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.946924	0	310,825	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	18,894,089	1,760	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	18,894,089	1,760	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/24/2024 1:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	388,730	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	522,441	0		54.00
60.00	06000	LABORATORY	299,370	0		60.00
65.00	06500	RESPIRATORY THERAPY	239,257	0		65.00
66.00	06600	PHYSICAL THERAPY	120,451	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	55,355	0		67.00
68.00	06800	SPEECH PATHOLOGY	14,746	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,192	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	77,595	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	797,771	250		73.00
76.97	07697	CARDIAC REHABILITATION	67,306	0		76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	432,208	0		90.01
91.00	09100	EMERGENCY	755,348	169		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	294,328	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	4,085,098	419		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,085,098	419		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1323 | Component CCN: 15-Z323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/24/2024 1:36 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.164550	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.914051	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123276	0	0	0	0	54.00
60.00	06000	LABORATORY	0.116651	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.193796	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.439499	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.689537	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.620274	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.154355	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.259115	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264867	0	0	1,259	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.334338	0	0	0	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0.854890	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.206679	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.946924	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	1,259	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	1,259	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1323 | Component CCN: 15-Z323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 5/24/2024 1:36 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	333		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	333		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	333		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/24/2024 1:36 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	838,768	135,705	703,063	3,106	226.36	30.00
43.00	NURSERY	22,969		22,969	175	131.25	43.00
200.00	Total (lines 30 through 199)	861,737		726,032	3,281		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	25	5,659				30.00
43.00	NURSERY	6	788				43.00
200.00	Total (lines 30 through 199)	31	6,447				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/24/2024 1:36 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	451,768	25,711,458	0.017571	86,998	1,529	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	84,757	1,360,981	0.062276	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	288,056	31,152,109	0.009247	23,972	222	54.00
60.00	06000	LABORATORY	142,489	19,203,201	0.007420	48,827	362	60.00
65.00	06500	RESPIRATORY THERAPY	72,735	7,287,118	0.009981	4,663	47	65.00
66.00	06600	PHYSICAL THERAPY	75,502	1,625,937	0.046436	852	40	66.00
67.00	06700	OCCUPATIONAL THERAPY	50,350	696,785	0.072260	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	18,148	278,909	0.065068	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,973	2,009,325	0.008945	117	1	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,210	1,679,343	0.015012	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	184,606	14,311,567	0.012899	31,285	404	73.00
76.97	07697	CARDIAC REHABILITATION	26,527	565,101	0.046942	0	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	50,997	790,139	0.064542	0	0	90.01
91.00	09100	EMERGENCY	446,357	30,866,319	0.014461	43,070	623	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	232,696	1,999,062	0.116403	3,600	419	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,168,171	139,537,354		243,384	3,647	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/24/2024 1:36 pm

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	3,106	0.00	25	30.00
43.00	04300	NURSERY		0	175	0.00	6	43.00
200.00		Total (lines 30 through 199)		0	3,281		31	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
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: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/24/2024 1:36 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	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 PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/24/2024 1:36 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	25,711,458	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,360,981	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	31,152,109	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	19,203,201	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,287,118	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,625,937	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	696,785	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	278,909	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,009,325	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,679,343	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,311,567	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	565,101	0.000000	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	0	0	790,139	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	30,866,319	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,999,062	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	139,537,354		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/24/2024 1:36 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	86,998	0	0	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	23,972	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	48,827	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,663	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	852	0	0	0	66.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	117	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	31,285	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	43,070	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	3,600	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		243,384	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/24/2024 1:36 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.164550	0	60,513	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.914051	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123276	0	306,772	0	0	54.00
60.00	06000	LABORATORY	0.116651	0	198,733	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.193796	0	23,014	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.439499	0	18,184	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.689537	0	7,808	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.620274	0	4,301	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.154355	0	4,092	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.259115	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264867	0	43,958	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.334338	0	0	0	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0.854890	0	86	0	0	90.01
91.00	09100	EMERGENCY	0.206679	0	559,445	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.946924	0	32,248	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	1,259,154	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	1,259,154	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/24/2024 1:36 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	9,957	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	37,818	0		54.00
60.00	06000	LABORATORY	23,182	0		60.00
65.00	06500	RESPIRATORY THERAPY	4,460	0		65.00
66.00	06600	PHYSICAL THERAPY	7,992	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,384	0		67.00
68.00	06800	SPEECH PATHOLOGY	2,668	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	632	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,643	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	74	0		90.01
91.00	09100	EMERGENCY	115,626	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	30,536	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	249,972	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	249,972	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 1:36 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,750	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,106	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)	2,078	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	592	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	52	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)	595	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)	205	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	266.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	266.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,823,327	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)	13,849	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)	1,103,952	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,719,375	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,719,375	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,841.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,095,627	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)	1,095,627	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 1:36 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	485,381	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)	1,581,008	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	377,485	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	377,485	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,028	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,841.40	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,892,959	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 1:36 pm

Title XVIII | Hospital | Cost

	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	838,768	6,823,327	0.122927	1,892,959	232,696	90.00
91.00	Nursing Program cost	0	6,823,327	0.000000	1,892,959	0	91.00
92.00	Allied health cost	0	6,823,327	0.000000	1,892,959	0	92.00
93.00	All other Medical Education	0	6,823,327	0.000000	1,892,959	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 1:36 pm

Title XIX | Hospital | PPS

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,750	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,106	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)	2,078	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	592	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	52	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)	25	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)	175	15.00
16.00	Nursery days (title V or XIX only)	6	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	266.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	266.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,823,327	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)	13,849	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)	1,103,952	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,719,375	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,719,375	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,841.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	46,035	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	46,035	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 1:36 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	384,543	175	2,197.39	6	13,184	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	44,860	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)	104,079	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	6,447	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	3,647	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	10,094	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	93,985	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,028	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,841.40	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,892,959	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 1:36 pm

Title XIX | Hospital | PPS

	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	838,768	6,823,327	0.122927	1,892,959	232,696	90.00
91.00	Nursing Program cost	0	6,823,327	0.000000	1,892,959	0	91.00
92.00	Allied health cost	0	6,823,327	0.000000	1,892,959	0	92.00
93.00	All other Medical Education	0	6,823,327	0.000000	1,892,959	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/24/2024 1:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,279,874		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.164550	770,379	126,766	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.914051	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123276	139,271	17,169	54.00
60.00	06000	LABORATORY	0.116651	427,833	49,907	60.00
65.00	06500	RESPIRATORY THERAPY	0.193796	331,977	64,336	65.00
66.00	06600	PHYSICAL THERAPY	0.439499	37,465	16,466	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.689537	53,557	36,930	67.00
68.00	06800	SPEECH PATHOLOGY	0.620274	18,617	11,548	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.154355	103,307	15,946	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.259115	62,478	16,189	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264867	451,842	119,678	73.00
76.97	07697	CARDIAC REHABILITATION	0.334338	0	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0.854890	1,892	1,617	90.01
91.00	09100	EMERGENCY	0.206679	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.946924	9,324	8,829	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,407,942	485,381	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)		2,407,942		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3

Component CCN: 15-Z323 | Date/Time Prepared: 5/24/2024 1:36 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.164550	1,111	183	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.914051	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123276	7,211	889	54.00
60.00	06000	LABORATORY	0.116651	47,647	5,558	60.00
65.00	06500	RESPIRATORY THERAPY	0.193796	6,919	1,341	65.00
66.00	06600	PHYSICAL THERAPY	0.439499	40,842	17,950	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.689537	78,695	54,263	67.00
68.00	06800	SPEECH PATHOLOGY	0.620274	2,889	1,792	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.154355	1,860	287	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.259115	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264867	50,386	13,346	73.00
76.97	07697	CARDIAC REHABILITATION	0.334338	0	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0.854890	129	110	90.01
91.00	09100	EMERGENCY	0.206679	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.946924	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		237,689	95,719	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)		237,689		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/24/2024 1:36 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		105,302		30.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.164550	86,998	14,316	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.914051	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123276	23,972	2,955	54.00
60.00	06000	LABORATORY	0.116651	48,827	5,696	60.00
65.00	06500	RESPIRATORY THERAPY	0.193796	4,663	904	65.00
66.00	06600	PHYSICAL THERAPY	0.439499	852	374	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.689537	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.620274	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.154355	117	18	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.259115	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264867	31,285	8,286	73.00
76.97	07697	CARDIAC REHABILITATION	0.334338	0	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0.854890	0	0	90.01
91.00	09100	EMERGENCY	0.206679	43,070	8,902	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.946924	3,600	3,409	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		243,384	44,860	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)		243,384		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1323	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/24/2024 1:36 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,085,517	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,085,517	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	4,126,372	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	46,916	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,245,338	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)	834,118	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)	834,118	30.00
31.00	Primary payer payments	686	31.00
32.00	Subtotal (line 30 minus line 31)	833,432	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	546,533	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	355,246	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	142,084	36.00
37.00	Subtotal (see instructions)	1,188,678	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,188,678	40.00
40.01	Sequestration adjustment (see instructions)	23,774	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	1,057,927	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)	106,977	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1323	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/24/2024 1:36 pm
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2024 1:36 pm

Title XVIII | Hospital | Cost

		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		1,243,235		1,057,927	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	08/23/2023	125,200		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)		125,200		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)		1,368,435		1,057,927	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		106,977	6.01
6.02	SETTLEMENT TO PROGRAM		4,641		0	6.02
7.00	Total Medicare program liability (see instructions)		1,363,794		1,164,904	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1323 | Component CCN: 15-Z323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2024 1:36 pm

Title XVIII | Swing Beds - SNF | Cost

		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		457,848		247	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	08/24/2023	32,000		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)		32,000		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)		489,848		247	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		82	6.01
6.02	SETTLEMENT TO PROGRAM		25,979		0	6.02
7.00	Total Medicare program liability (see instructions)		463,869		329	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: 15-1323	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/24/2024 1:36 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1323 | Component CCN: 15-Z323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/24/2024 1:36 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	381,260	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	96,676	336	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	205	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	477,936	336	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	477,936	336	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	477,936	336	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,600	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	473,336	336	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	473,336	336	19.00
19.01	Sequestration adjustment (see instructions)	9,467	7	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	489,848	247	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	-25,979	82	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1323	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/24/2024 1:36 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,581,008	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	1,581,008	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,596,818	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,596,818	19.00
20.00	Deductibles (exclude professional component)	235,068	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,361,750	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,361,750	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	45,965	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	29,877	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,391,627	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,391,627	30.00
30.01	Sequestration adjustment (see instructions)	27,833	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,368,435	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-4,641	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/24/2024 1:36 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,757	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	5,780,454	0	0	0	4.00
5.00	Other receivable	1,918	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	460,297	0	0	0	7.00
8.00	Prepaid expenses	24,291	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	8,716,411	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	14,985,128	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	320,702	0	0	0	12.00
13.00	Land improvements	2,011,654	0	0	0	13.00
14.00	Accumulated depreciation	-1,527,695	0	0	0	14.00
15.00	Buildings	13,299,654	0	0	0	15.00
16.00	Accumulated depreciation	-5,746,928	0	0	0	16.00
17.00	Leasehold improvements	15,320	0	0	0	17.00
18.00	Accumulated depreciation	-15,320	0	0	0	18.00
19.00	Fixed equipment	9,242,962	0	0	0	19.00
20.00	Accumulated depreciation	-7,594,560	0	0	0	20.00
21.00	Automobiles and trucks	61,324	0	0	0	21.00
22.00	Accumulated depreciation	-61,324	0	0	0	22.00
23.00	Major movable equipment	10,822,389	0	0	0	23.00
24.00	Accumulated depreciation	-8,509,143	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)	12,319,035	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	5,011,241	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,011,241	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	32,315,404	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,245,486	0	0	0	37.00
38.00	Salaries, wages, and fees payable	657,349	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,130,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,178,274	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,211,109	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	11,090,919	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,090,919	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	15,302,028	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	17,013,376				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)	17,013,376	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	32,315,404	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/24/2024 1:36 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		14,404,723		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,989,735				2.00
3.00	Total (sum of line 1 and line 2)		16,394,458		0		3.00
4.00	OTHER	344,999		0		0	4.00
5.00	NON-ALLOWABLE HO INTEREST EXP	273,918		0		0	5.00
6.00	ROUNDING	1		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)		618,918		0		10.00
11.00	Subtotal (line 3 plus line 10)		17,013,376		0		11.00
12.00	OTHER	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		17,013,376		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	OTHER		0			4.00
5.00	NON-ALLOWABLE HO INTEREST EXP		0			5.00
6.00	ROUNDING		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	OTHER		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/24/2024 1:36 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,519,126		7,519,126	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)	7,519,126		7,519,126	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	7,519,126		7,519,126	17.00
18.00	Ancillary services	13,358,582	91,162,269	104,520,851	18.00
19.00	Outpatient services	930,890	32,839,798	33,770,688	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	Other Patient Service Revenue	0	27,789	27,789	27.00
27.01	Other Patient Service Revenue - NRCCs	135,567	5,743,415	5,878,982	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	21,944,165	129,773,271	151,717,436	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		39,778,065		29.00
30.00	NON-ALLOWABLE HO INTEREST EXP	273,918			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		273,918		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)		40,051,983		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1323 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 5/24/2024 1:36 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	151,717,436	1.00
2.00	Less contractual allowances and discounts on patients' accounts	110,050,198	2.00
3.00	Net patient revenues (line 1 minus line 2)	41,667,238	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	40,051,983	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,615,255	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	248,355	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	28,128	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	4,800	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	19,056	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	37,742	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.02	MISCELLANEOUS OTHER OPERATING	29,150	24.02
24.03	TRANSFER FROM FOUNDATION	7,249	24.03
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	374,480	25.00
26.00	Total (line 5 plus line 25)	1,989,735	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)	1,989,735	29.00