

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: 15-0172	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/30/2024 4:59 pm
--	-----------------------	---	--

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 5/30/2024	Time: 4:59 pm
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PHYSICIANS MEDICAL CENTER (15-0172) 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	Dennis Medley	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	Dennis Medley		2
3	Signatory Title	CEO		3
4	Date	(Dated when report is electronic)		4

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	22,154	1	0	4,248,367
2.00	SUBPROVIDER - IPF	0	0	0	0	0
3.00	SUBPROVIDER - IRF	0	0	0	0	0
5.00	SWING BED - SNF	0	0	0	0	0
6.00	SWING BED - NF	0	0	0	0	0
200.00	TOTAL	0	22,154	1	0	4,248,367

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: 15-0172		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 4:59 pm				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 4023 REES LANE			PO Box:				1.00				
2.00	City: NEW ALBANY			State: IN		Zip Code: 47150		County: FLOYD				
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
								V	XVIII			
								XIX				
Hospital and Hospital-Based Component Identification:												
3.00	Hospital			PHYSICIANS MEDICAL CENTER	150172	31140	1	10/30/2008	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2023	12/31/2023		20.00		
21.00	Type of Control (see instructions)						4			21.00		
							1.00	2.00		3.00		
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00			
22.01	Did this hospital receive interim UCPS, including supplemental UCPS, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01			
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N	22.03		
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.									22.04		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N		23.00			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet S-2
Part I
Date/Time Prepared:
5/30/2024 4:59 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	3	0	96	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.					1		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)					N	N	N
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
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
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
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		
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.							
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		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 15-0172		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 4:59 pm	
			V	XVIII	XIX			
			1.00	2.00	3.00			
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.						N	59.00
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
			1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.			N			60.00	
			Y/N	IME	Direct GME	IME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)					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: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet S-2
Part I
Date/Time Prepared:
5/30/2024 4:59 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

Health Financial Systems		PHYSICIANS MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0172	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 4:59 pm	
			1.00		
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?			68.00	
			1.00	2.00	3.00
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	Y 91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N 92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N 93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N 94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00 95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N 96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00 97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0172		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 4:59 pm	
				V	XIX		
				1.00	2.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y			98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y			98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y			98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N			98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N			98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y			98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y			98.06	
Rural Providers							
105.00	Does this hospital qualify as a CAH?	N				105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	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				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.	2				118.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0172	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 4:59 pm
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	142,213	38,653	0
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	N	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	HB0583	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: SURGICAL CARE AFFILIATES	Contractor's Name: PALMETTO GBA	Contractor's Number: 10101	141.00
142.00	Street: 569 BROOKWOOD VILLAGE, SUITE 901	PO Box:		142.00
143.00	City: BIRMINGHAM	State: AL	Zip Code: 35209	143.00
				1.00
144.00	Are provider based physicians' costs included in Worksheet A?		N	144.00
				1.00
				2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			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: 15-0172		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 4:59 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	
						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)						9.99	169.00
				Beginning	Ending			
				1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00
				1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0172		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part II Date/Time Prepared: 5/30/2024 4:59 pm	
				Y/N	Date		
				1.00	2.00		
PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE							
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	09/30/2023			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.	N					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	04/11/2024	Y	04/11/2024		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: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet S-2
Part II
Date/Time Prepared:
5/30/2024 4:59 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				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
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.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
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.	KEVIN	CALLAWAY		41.00
42.00	Enter the employer/company name of the cost report preparer.	FORVIS, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	336-714-8151	KEVIN.CALLAWAY@FORVIS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet S-2
Part II
Date/Time Prepared:
5/30/2024 4:59 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.	PRINCIPAL		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: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part I
Date/Time Prepared:
5/30/2024 4:59 pm

Component	Worksheet A Line No.	No. of Beds	Bed Days Avai lable	CAH/REH Hours	I/P Days / O/P Vi si ts / Tri ps		
					Title V		
					1.00		2.00
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	10	3,650	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		10	3,650	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		10	3,650	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		10				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: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part I
Date/Time Prepared:
5/30/2024 4:59 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)	158	3	709			1.00
2.00	HMO and other (see instructions)	125	96				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	158	3	709			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)	158	3	709	0.00	187.52	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	187.52	27.00
28.00	Observation Bed Days		0	1,539			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part I
Date/Time Prepared:
5/30/2024 4:59 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
	Nonpaid Workers					
	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	86	1	376	1.00
2.00 HMO and other (see instructions)			68	52		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	86	1	376	14.00
15.00 CAH visits						15.00
15.10 REH hours and visits						15.10
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01
34.00 Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part II
Date/Time Prepared:
5/30/2024 4:59 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 + col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	13,909,129	0	13,909,129	390,032.00	35.66
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		88,881	0	88,881	1,364.00	65.16
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		1,871,051	0	1,871,051	19,614.64	95.39
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		3,353,472	0	3,353,472		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		0	0	0		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		215,052	0	215,052		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part II
Date/Time Prepared:
5/30/2024 4:59 pm

		Wkst. A Line Number	Amount Reported	Recl assi fication of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	88,170	0	88,170	0.00	0.00	26.00
27.00	Administrative & General	5.00	3,464,352	-205,572	3,258,780	88,912.00	36.65	27.00
28.00	Administrative & General under contract (see inst.)		53,134	0	53,134	129.00	411.89	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	158,674	0	158,674	5,612.00	28.27	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		249,732	0	249,732	10,790.00	23.14	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		6,005	0	6,005	133.00	45.15	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	168,666	168,666	1,864.00	90.49	38.00
39.00	Central Services and Supply	14.00	616,958	0	616,958	20,458.00	30.16	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	122,746	36,906	159,652	7,456.00	21.41	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part III
Date/Time Prepared:
5/30/2024 4:59 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	14,218,000	0	14,218,000	401,084.00	35.45	1.00
2.00	Excluded area salaries (see instructions)	0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	14,218,000	0	14,218,000	401,084.00	35.45	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,959,932	0	1,959,932	20,978.64	93.43	4.00
5.00	Subtotal wage-related costs (see inst.)	3,568,524	0	3,568,524	0.00	25.10	5.00
6.00	Total (sum of lines 3 thru 5)	19,746,456	0	19,746,456	422,062.64	46.79	6.00
7.00	Total overhead cost (see instructions)	4,759,771	0	4,759,771	135,354.00	35.17	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part IV
Date/Time Prepared:
5/30/2024 4:59 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	379,065	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	1,578,583	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	151,304	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	138,677	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	845,499	17.00
18.00	Medicare Taxes - Employers Portion Only	175,644	18.00
19.00	Unemployment Insurance	69,570	19.00
20.00	State or Federal Unemployment Taxes	11,630	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	3,500	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,353,472	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part V
Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	88,881	3,353,472	1.00
2.00	Hospital	88,881	3,353,472	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet S-10
Parts I & II
Date/Time Prepared:
5/30/2024 4:59 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)		0.219574	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		3,329,475	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		13,717,318	6.00
7.00	Medicaid cost (line 1 times line 6)		3,011,966	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		0	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	0	0	0
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	0	0	0
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (see instructions)	0	0	0
			1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
25.01	Charges for insured patients' liability (see instructions)		0	25.01
26.00	Bad debt amount (see instructions)		0	26.00
27.00	Medicare reimbursable bad debts (see instructions)		0	27.00
27.01	Medicare allowable bad debts (see instructions)		0	27.01
28.00	Non-Medicare bad debt amount (see instructions)		0	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		0	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		0	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		0	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet S-10
Parts I & II
Date/Time Prepared:
5/30/2024 4:59 pm

			1.00	
PART II - HOSPITAL DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)		0.219574	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)	0	0	0 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	0	0	0 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)	0	0	0 23.00
			1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
25.01	Charges for insured patients' liability (see instructions)		0	25.01
26.00	Bad debt amount (see instructions)		0	26.00
27.00	Medicare reimbursable bad debts (see instructions)		0	27.00
27.01	Medicare allowable bad debts (see instructions)		0	27.01
28.00	Non-Medicare bad debt amount (see instructions)		0	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		0	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		0	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		0	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0172

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

Worksheet A

Date/Time Prepared:
5/30/2024 4:59 pm

	Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified ations (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		2,812,688	0	2,812,688	1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP		809,714	0	809,714	2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	88,170	22,861	0	111,031	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	3,464,352	9,772,145	-418,641	12,817,856	5.00	
7.00	00700	OPERATION OF PLANT	158,674	190,155	0	348,829	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	461,710	0	461,710	8.00	
9.00	00900	HOUSEKEEPING	0	282,680	0	282,680	9.00	
10.00	01000	DIETARY	0	54,123	6,005	60,128	10.00	
13.00	01300	NURSING ADMINISTRATION	0	0	212,906	212,906	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	616,958	146,530	0	763,488	14.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	122,746	34,320	157,066	46,586	203,652	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,306,523	947,163	5,253,686	213,355	5,467,041	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,798,853	3,592,495	8,391,348	-279,755	8,111,593	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	314,920	103,554	418,474	66,400	484,874	54.00
60.00	06000	LABORATORY	0	237,669	237,669	64,638	302,307	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	88,506	88,506	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,535,132	6,535,132	0	6,535,132	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,642,588	7,642,588	0	7,642,588	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,933	870,861	908,794	0	908,794	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,909,129	34,516,388	48,425,517	0	48,425,517	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	13,909,129	34,516,388	48,425,517	0	48,425,517	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0172

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

Worksheet A

Date/Time Prepared:
5/30/2024 4:59 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	30,619	2,843,307	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	63,532	873,246	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	111,031	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,448,279	14,266,135	5.00
7.00	00700	OPERATION OF PLANT	0	348,829	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	461,710	8.00
9.00	00900	HOUSEKEEPING	0	282,680	9.00
10.00	01000	DIETARY	0	60,128	10.00
13.00	01300	NURSING ADMINISTRATION	0	212,906	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	763,488	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	203,652	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	5,467,041	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,974	8,109,619	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	484,874	54.00
60.00	06000	LABORATORY	0	302,307	60.00
66.00	06600	PHYSICAL THERAPY	0	88,506	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,535,132	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,642,588	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	908,794	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,540,456	49,965,973	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	1,540,456	49,965,973	200.00

RECLASSIFICATIONS

Provider CCN: 15-0172

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

Worksheet A-6

Date/Time Prepared:
5/30/2024 4:59 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CONTRACT SERVICES RECLASS				
1.00	DI ETARY	10.00	0	6,005	1.00
2.00	LABORATORY	60.00	0	64,638	2.00
3.00	PHYSI CAL THERAPY	66.00	0	88,506	3.00
	0		0	159,149	
	B - SALARIES RECLASS				
1.00	NURSI NG ADMI NI STRATION	13.00	168,666	44,240	1.00
2.00	MEDI CAL RECORDS & LI BRARY	16.00	36,906	9,680	2.00
3.00	ADULTS & PEDI ATRI CS	30.00	169,022	44,333	3.00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	52,603	13,797	4.00
	0		427,197	112,050	
500.00	Grand Total: Increases		427,197	271,199	500.00

RECLASSIFICATIONS

Provider CCN: 15-0172

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

Worksheet A-6

Date/Time Prepared:
5/30/2024 4:59 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - CONTRACT SERVICES RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	159,149	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	0		0	159,149		
B - SALARIES RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	205,572	53,920	0	1.00
2.00	OPERATING ROOM	50.00	221,625	58,130	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
	0		427,197	112,050		
500.00	Grand Total: Decreases		427,197	271,199		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet A-7
Part I
Date/Time Prepared:
5/30/2024 4:59 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	0	0	0	0	0	1.00	
2.00	Land Improvements	0	0	0	0	0	2.00	
3.00	Buildings and Fixtures	0	0	0	0	0	3.00	
4.00	Building Improvements	1,074,748	567,221	0	567,221	0	4.00	
5.00	Fixed Equipment	254,682	0	0	0	100,740	5.00	
6.00	Movable Equipment	15,665,872	0	0	0	12,338,833	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	16,995,302	567,221	0	567,221	12,439,573	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	16,995,302	567,221	0	567,221	12,439,573	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0				1.00	
2.00	Land Improvements	0	0				2.00	
3.00	Buildings and Fixtures	0	0				3.00	
4.00	Building Improvements	1,641,969	0				4.00	
5.00	Fixed Equipment	153,942	0				5.00	
6.00	Movable Equipment	3,327,039	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	5,122,950	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	5,122,950	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet A-7
Part II
Date/Time Prepared:
5/30/2024 4:59 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	66,186	2,746,502	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	809,714	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	875,900	2,746,502	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	2,812,688				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	809,714				2.00
3.00	Total (sum of lines 1-2)	0	3,622,402				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet A-7
Part III
Date/Time Prepared:
5/30/2024 4:59 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	1,641,969	0	1,641,969	0.320512	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,480,980	0	3,480,980	0.679488	0	2.00
3.00	Total (sum of lines 1-2)	5,122,949	0	5,122,949	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital -Related Costs	Total (sum of col.s. 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	140,154	2,746,502	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	873,246	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,013,400	2,746,502	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 col.s. 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	-43,349	0	0	0	2,843,307	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	873,246	2.00
3.00	Total (sum of lines 1-2)	-43,349	0	0	0	3,716,553	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0172

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

Worksheet A-8

Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	-43,349	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0		0.00	0	3.00
4.00	Investment income - other (chapter 2)		0		0.00	0	4.00
5.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	5.00
6.00	Refunds and rebates of expenses (chapter 8)	B	0	0ADMINISTRATIVE & GENERAL	5.00	0	6.00
7.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	7.00
8.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	8.00
9.00	Television and radio service (chapter 21)		0		0.00	0	9.00
10.00	Parking lot (chapter 21)	A-8-2	0		0.00	0	10.00
11.00	Provider-based physician adjustment		0		0.00	0	11.00
12.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	12.00
13.00	Related organization transactions (chapter 10)	A-8-1	1,887,603			0	13.00
14.00	Laundry and linen service		0		0.00	0	14.00
15.00	Cafeteria-employees and guests		0		0.00	0	15.00
16.00	Rental of quarters to employee and others	B	0	0CAP REL COSTS-BLDG & FIXT	1.00	10	16.00
17.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	17.00
18.00	Sale of drugs to other than patients		0		0.00	0	18.00
19.00	Sale of medical records and abstracts	B	0	0MEDICAL RECORDS & LIBRARY	16.00	0	19.00
20.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	20.00
21.00	Vending machines		0		0.00	0	21.00
22.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	22.00
23.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	23.00
24.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		24.00
25.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0PHYSICAL THERAPY	66.00		25.00
26.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		26.00
27.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	0CAP REL COSTS-BLDG & FIXT	1.00	0	27.00
28.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	0CAP REL COSTS-MVBLE EQUIP	2.00	0	28.00
29.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		29.00
30.00	Physicians' assistant		0	0	0.00	0	30.00
30.99	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.99
31.00	Hospice (non-distinct) (see instructions)		0	0ADULTS & PEDIATRICS	30.00		31.00
32.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		32.00
33.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	33.00
	MARKETING EXPENSE	A	-15,258	ADMINISTRATIVE & GENERAL	5.00	0	

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0172

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

Worksheet A-8

Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	MARKETING EXPENSE	A	-1,974	OPERATING ROOM	50.00	0	33.01
34.00	LATE CHARGE FEES	A	-66	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	LEGAL FEES	A	-57,500	ADMINISTRATIVE & GENERAL	5.00	0	34.01
35.00	SURGEON ON CALL COVERAGE	A	-31,000	ADMINISTRATIVE & GENERAL	5.00	0	35.00
35.01	LOBBYING (AMA)	A	0	ADMINISTRATIVE & GENERAL	5.00	0	35.01
36.00	HOSPITALIST	A	-198,000	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	PROVIDER STATE ASSESSMENT	A	0	ADMINISTRATIVE & GENERAL	5.00	0	37.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,540,456				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 15-0172

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

Worksheet A-8-1

Date/Time Prepared:
5/30/2024 4:59 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	SCA HOME OFFICE	2,500,103	750,000	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	SCA HOME OFFICE	73,968	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	SCA HOME OFFICE	63,532	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.			2,637,603	750,000	5.00

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

	Symbol (1)	Name	Percentage of Ownership	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	SURGICAL CARE A	54.06	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: 15-0172	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Date/Time Prepared: 5/30/2024 4:59 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	1,750,103	0		1.00
2.00	73,968	9		2.00
3.00	63,532	9		3.00
4.00	0	0		4.00
5.00	1,887,603			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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

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

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part I
Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,843,307	2,843,307			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	873,246		873,246		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	111,031	0	0	111,031	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,266,135	440,838	135,392	26,181	5.00
7.00	00700	OPERATION OF PLANT	348,829	114,479	35,159	1,275	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	461,710	0	0	0	8.00
9.00	00900	HOUSEKEEPING	282,680	25,440	7,813	0	9.00
10.00	01000	DIETARY	60,128	27,678	8,500	0	10.00
13.00	01300	NURSING ADMINISTRATION	212,906	0	0	1,355	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	763,488	755,243	231,953	4,957	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	203,652	28,149	8,645	1,283	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,467,041	465,336	142,916	35,957	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,109,619	977,782	300,300	36,765	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	484,874	8,362	2,568	2,953	54.00
60.00	06000	LABORATORY	302,307	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	88,506	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,535,132	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,642,588	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	908,794	0	0	305	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,965,973	2,843,307	873,246	111,031	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	49,965,973	2,843,307	873,246	111,031	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part I
Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,868,546					5.00
7.00	00700	OPERATION OF PLANT	211,709	711,451				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	195,597	0	657,307			8.00
9.00	00900	HOUSEKEEPING	133,841	7,911	0	457,685		9.00
10.00	01000	DIETARY	40,799	8,606	0	5,599	151,310	10.00
13.00	01300	NURSING ADMINISTRATION	90,769	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	743,753	234,843	0	152,776	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	102,405	8,753	0	5,694	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,588,946	144,696	32,865	94,132	151,310	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,992,555	304,042	624,442	197,792	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	211,291	2,600	0	1,692	0	54.00
60.00	06000	LABORATORY	128,068	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	37,494	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,768,517	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,237,675	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	385,127	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,868,546	711,451	657,307	457,685	151,310	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,868,546	711,451	657,307	457,685	151,310	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part I
Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	14.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	305,030					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,887,013				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	358,581			16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	98,259	0	10,782	9,232,240	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	206,771	0	192,448	14,942,516	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,181	716,521	0	54.00
60.00	06000	LABORATORY	0	0	479	430,854	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	865	126,865	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,330,749	66,572	10,700,970	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,556,264	57,310	12,493,837	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	27,944	1,322,170	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	305,030	2,887,013	358,581	49,965,973	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	305,030	2,887,013	358,581	49,965,973	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part I
Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
66.00	06600	PHYSICAL THERAPY	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	77.00
OUTPATIENT SERVICE COST CENTERS			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM	102.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part II
Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	48,574	440,838	135,392	624,804	0 5.00
7.00	00700	OPERATION OF PLANT	4,934	114,479	35,159	154,572	0 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0 8.00
9.00	00900	HOUSEKEEPING	0	25,440	7,813	33,253	0 9.00
10.00	01000	DIETARY	0	27,678	8,500	36,178	0 10.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	755,243	231,953	987,196	0 14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,149	8,645	36,794	0 16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	465,336	142,916	608,252	0 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	232,666	977,782	300,300	1,510,748	0 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,362	2,568	10,930	0 54.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
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
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0 77.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0 102.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	286,174	2,843,307	873,246	4,002,727	0 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0 192.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	286,174	2,843,307	873,246	4,002,727	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part II
Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	624,804					5.00
7.00	00700	OPERATION OF PLANT	8,896	163,468				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,219	0	8,219			8.00
9.00	00900	HOUSEKEEPING	5,624	1,818	0	40,695		9.00
10.00	01000	DIETARY	1,714	1,977	0	498	40,367	10.00
13.00	01300	NURSING ADMINISTRATION	3,814	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	31,254	53,959	0	13,584	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,303	2,011	0	506	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	108,792	33,246	411	8,370	40,367	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	167,776	69,860	7,808	17,587	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,879	597	0	150	0	54.00
60.00	06000	LABORATORY	5,382	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	1,576	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	116,338	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	136,053	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,184	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	624,804	163,468	8,219	40,695	40,367	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	624,804	163,468	8,219	40,695	40,367	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part II
Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	14.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
13.00	01300	NURSING ADMINISTRATION	3,814				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,085,993			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	43,614		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,229	0	1,311	801,978	0 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,585	0	23,409	1,799,773	0 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	265	20,821	0 54.00
60.00	06000	LABORATORY	0	0	58	5,440	0 60.00
66.00	06600	PHYSICAL THERAPY	0	0	105	1,681	0 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	500,585	8,097	625,020	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	585,408	6,970	728,431	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,399	19,583	0 73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0 77.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0 102.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,814	1,085,993	43,614	4,002,727	0 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0 192.00
200.00		Cross Foot Adjustments				0	0 200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	3,814	1,085,993	43,614	4,002,727	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part II
Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
66.00	06600	PHYSICAL THERAPY	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	77.00
OUTPATIENT SERVICE COST CENTERS			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM	102.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0172

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

Worksheet B-1

Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	48,283				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		48,283			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	13,820,959		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,486	7,486	3,258,780	-14,868,546	5.00
7.00	00700	OPERATION OF PLANT	1,944	1,944	158,674	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	432	432	0	0	9.00
10.00	01000	DIETARY	470	470	0	0	10.00
13.00	01300	NURSING ADMINISTRATION	0	0	168,666	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,825	12,825	616,958	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	478	478	159,652	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,902	7,902	4,475,545	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,604	16,604	4,577,228	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	142	142	367,523	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	37,933	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,283	48,283	13,820,959	-14,868,546	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,843,307	873,246	111,031	14,868,546	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	58.888367	18.085993	0.008034	0.423636	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	624,804	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	0.017802	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: 15-0172

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

Worksheet B-1

Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	NURSING ADMINISTRATION (NURSING HOURS)	
			7.00	8.00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	38,853					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	100				8.00
9.00	00900	HOUSEKEEPING	432	0	38,421			9.00
10.00	01000	DIETARY	470	0	470	100		10.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	172,474	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,825	0	12,825	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	478	0	478	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,902	5	7,902	100	55,559	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	16,604	95	16,604	0	116,915	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	142	0	142	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,853	100	38,421	100	172,474	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	711,451	657,307	457,685	151,310	305,030	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.311353	6,573.070000	11.912366	1,513.100000	1.768556	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	163,468	8,219	40,695	40,367	3,814	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.207346	82.190000	1.059186	403.670000	0.022113	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: 15-0172

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

Worksheet B-1

Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		14.00	16.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,177,720	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	108,358,388	54.00
60.00	06000	LABORATORY	1,227,969	60.00
66.00	06600	PHYSICAL THERAPY	269,663	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	487,172	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,535,132	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,642,588	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	77.00
OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	102.00
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,177,720	118.00
NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	192.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,887,013	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.203630	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,085,993	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.076599	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: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/30/2024 4:59 pm

				Title XVIII		Hospital		PPS		
Cost Center Description				Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
						Total Costs	RCE Disallowance	Total Costs		
				1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	9,232,240			9,232,240	0	9,232,240	30.00	
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	14,942,516			14,942,516	0	14,942,516	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	716,521			716,521	0	716,521	54.00	
60.00	06000	LABORATORY	430,854			430,854	0	430,854	60.00	
66.00	06600	PHYSICAL THERAPY	126,865	0		126,865	0	126,865	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,700,970			10,700,970	0	10,700,970	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,493,837			12,493,837	0	12,493,837	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,322,170			1,322,170	0	1,322,170	73.00	
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0			0	0	0	77.00	
	OUTPATIENT SERVICE COST CENTERS									
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,320,473			6,320,473		6,320,473	92.00	
	OTHER REIMBURSABLE COST CENTERS									
102.00	10200	OPIOID TREATMENT PROGRAM	0			0		0	102.00	
200.00		Subtotal (see instructions)	56,286,446	0		56,286,446	0	56,286,446	200.00	
201.00		Less Observation Beds	6,320,473			6,320,473		6,320,473	201.00	
202.00		Total (see instructions)	49,965,973	0		49,965,973	0	49,965,973	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/30/2024 4:59 pm

			Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	595,602		595,602			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	45,704,805	88,442,688	134,147,493	0.111389	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	348,175	880,805	1,228,980	0.583021	0.000000	54.00
60.00	06000	LABORATORY	177,278	92,899	270,177	1.594710	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	455,688	32,879	488,567	0.259668	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,383,585	17,159,991	37,543,576	0.285028	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,713,349	8,624,820	32,338,169	0.386350	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,296,026	6,465,410	15,761,436	0.083886	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
	OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,125,945	3,058,927	5,184,872	1.219022	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	102,800,453	124,758,419	227,558,872			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	102,800,453	124,758,419	227,558,872			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.111389			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.583021			54.00
60.00	06000 LABORATORY	1.594710			60.00
66.00	06600 PHYSICAL THERAPY	0.259668			66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.285028			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.386350			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.083886			73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000			77.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.219022			92.00
OTHER REIMBURSABLE COST CENTERS					
102.00	10200 OPIOID TREATMENT PROGRAM				102.00
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: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/30/2024 4:59 pm

				Title XIX		Hospital		Cost		
Cost Center Description				Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
						Total Costs	RCE	Total Costs		
							Disallowance			
				1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	9,232,240			9,232,240	0	9,232,240	30.00	
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	14,942,516			14,942,516	0	14,942,516	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	716,521			716,521	0	716,521	54.00	
60.00	06000	LABORATORY	430,854			430,854	0	430,854	60.00	
66.00	06600	PHYSICAL THERAPY	126,865	0		126,865	0	126,865	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,700,970			10,700,970	0	10,700,970	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,493,837			12,493,837	0	12,493,837	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,322,170			1,322,170	0	1,322,170	73.00	
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0			0	0	0	77.00	
	OUTPATIENT SERVICE COST CENTERS									
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,320,473			6,320,473		6,320,473	92.00	
	OTHER REIMBURSABLE COST CENTERS									
102.00	10200	OPIOID TREATMENT PROGRAM	0			0		0	102.00	
200.00		Subtotal (see instructions)	56,286,446	0		56,286,446	0	56,286,446	200.00	
201.00		Less Observation Beds	6,320,473			6,320,473		6,320,473	201.00	
202.00		Total (see instructions)	49,965,973	0		49,965,973	0	49,965,973	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/30/2024 4:59 pm

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	595,602		595,602		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	45,704,805	88,442,688	134,147,493	0.111389	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	348,175	880,805	1,228,980	0.583021	0.000000
60.00	06000	LABORATORY	177,278	92,899	270,177	1.594710	0.000000
66.00	06600	PHYSICAL THERAPY	455,688	32,879	488,567	0.259668	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,383,585	17,159,991	37,543,576	0.285028	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,713,349	8,624,820	32,338,169	0.386350	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	9,296,026	6,465,410	15,761,436	0.083886	0.000000
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,125,945	3,058,927	5,184,872	1.219022	0.000000
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		
200.00		Subtotal (see instructions)	102,800,453	124,758,419	227,558,872		
201.00		Less Observation Beds					
202.00		Total (see instructions)	102,800,453	124,758,419	227,558,872		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
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
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000			77.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
102.00	10200 OPIOID TREATMENT PROGRAM				102.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part I
Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		801,978	0	801,978	2,248	356.75	30.00
200.00	Total (lines 30 through 199)		801,978		801,978	2,248		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		158	56,367				
200.00	Total (lines 30 through 199)		158	56,367				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part II
Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description			Title XVIII		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,799,773	134,147,493	0.013416	1,253,396	16,816
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,821	1,228,980	0.016942	5,338	90
60.00	06000	LABORATORY	5,440	270,177	0.020135	10,143	204
66.00	06600	PHYSICAL THERAPY	1,681	488,567	0.003441	11,681	40
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	625,020	37,543,576	0.016648	504,988	8,407
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	728,431	32,338,169	0.022525	672,939	15,158
73.00	07300	DRUGS CHARGED TO PATIENTS	19,583	15,761,436	0.001242	329,059	409
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	549,041	5,184,872	0.105893	3,750	397
200.00		Total (lines 50 through 199)	3,749,790	226,963,270		2,791,294	41,521

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 15-0172		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part III Date/Time Prepared: 5/30/2024 4:59 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00		
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	2,248	0.00	158	30.00		
200.00		Total (lines 30 through 199)		0	2,248		158	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0						30.00	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part IV
Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part IV
Date/Time Prepared:
5/30/2024 4:59 pm

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	134,147,493	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,228,980	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	270,177	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	488,567	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	37,543,576	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	32,338,169	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,761,436	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
	OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	5,184,872	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	226,963,270		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part IV
Date/Time Prepared:
5/30/2024 4:59 pm

				Title XVIII		Hospital		PPS		
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
										9.00
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	1,253,396	0	23,931,665	0	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	5,338	0	298,706	0	54.00	
60.00	06000	LABORATORY		0.000000	10,143	0	52,419	0	60.00	
66.00	06600	PHYSICAL THERAPY		0.000000	11,681	0	26,784	0	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	504,988	0	7,527,333	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	672,939	0	7,074,419	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	329,059	0	3,081,048	0	73.00	
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0.000000	0	0	0	0	77.00	
	OUTPATIENT SERVICE COST CENTERS									
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	3,750	0	1,718,266	0	92.00	
200.00		Total (lines 50 through 199)			2,791,294	0	43,710,640	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part V
Date/Time Prepared:
5/30/2024 4:59 pm

				Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.111389	23,931,665	0	0	2,665,724	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.583021	298,706	0	0	174,152	54.00	
60.00	06000	LABORATORY	1.594710	52,419	0	0	83,593	60.00	
66.00	06600	PHYSICAL THERAPY	0.259668	26,784	0	0	6,955	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.285028	7,527,333	0	0	2,145,501	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.386350	7,074,419	0	0	2,733,202	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.083886	3,081,048	0	0	258,457	73.00	
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00	
OUTPATIENT SERVICE COST CENTERS									
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.219022	1,718,266	0	0	2,094,604	92.00	
200.00		Subtotal (see instructions)		43,710,640	0	0	10,162,188	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		43,710,640	0	0	10,162,188	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part V
Date/Time Prepared:
5/30/2024 4:59 pm

				Title XVIII		Hospital		PPS	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					
60.00	06000	LABORATORY	0	0					
66.00	06600	PHYSICAL THERAPY	0	0					
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0					
OUTPATIENT SERVICE COST CENTERS									
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					
200.00		Subtotal (see instructions)	0	0					
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						
202.00		Net Charges (line 200 - line 201)	0	0					

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part V
Date/Time Prepared:
5/30/2024 4:59 pm

			Title XIX		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.111389	0	0	11,532,523	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.583021	0	0	159,722	0	54.00
60.00	06000	LABORATORY	1.594710	0	0	13,062	0	60.00
66.00	06600	PHYSICAL THERAPY	0.259668	0	0	2,170	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.285028	0	0	2,805,737	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.386350	0	0	506,332	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.083886	0	0	1,172,030	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.219022	0	0	458,063	0	92.00
200.00		Subtotal (see instructions)		0	0	16,649,639	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	16,649,639	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part V
Date/Time Prepared:
5/30/2024 4:59 pm

				Title XIX		Hospital		Cost	
Cost Center Description			Costs						
			Cost	Cost					
			Reimbursed	Reimbursed					
			Services Subject To Ded. & Coins. (see inst.)	Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	1,284,596					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	93,121					
60.00	06000	LABORATORY	0	20,830					
66.00	06600	PHYSICAL THERAPY	0	563					
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	799,714					
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	195,621					
73.00	07300	DRUGS CHARGED TO PATIENTS	0	98,317					
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0					
OUTPATIENT SERVICE COST CENTERS									
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	558,389					
200.00		Subtotal (see instructions)	0	3,051,151					
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						
202.00		Net Charges (line 200 - line 201)	0	3,051,151					

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0172	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/30/2024 4:59 pm
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,248	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,248	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)		709	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		158	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,232,240	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		9,232,240	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)		9,232,240	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)		4,106.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		648,885	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)		648,885	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0172

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

Worksheet D-1

Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)							42.00
	Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT							43.00
44.00	CORONARY CARE UNIT							44.00
45.00	BURN INTENSIVE CARE UNIT							45.00
46.00	SURGICAL INTENSIVE CARE UNIT							46.00
47.00	OTHER SPECIAL CARE (SPECIFY)							47.00
	Cost Center Description							
						1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					598,035		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)					1,246,920		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)					56,367		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					41,521		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					97,888		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,149,032		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)					1,539		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					4,106.87		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					6,320,473		89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0172

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

Worksheet D-1

Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	801,978	9,232,240	0.086867	6,320,473	549,041	90.00
91.00	Nursing Program cost	0	9,232,240	0.000000	6,320,473	0	91.00
92.00	Allied health cost	0	9,232,240	0.000000	6,320,473	0	92.00
93.00	All other Medical Education	0	9,232,240	0.000000	6,320,473	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0172	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/30/2024 4:59 pm
		Title XIX	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)		2,248	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,248	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)		709	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		3	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,232,240	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		9,232,240	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)		9,232,240	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)		4,106.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		12,321	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)		12,321	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0172

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

Worksheet D-1

Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,184,895	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)					1,197,216	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,539	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					4,106.87	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					6,320,473	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0172

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

Worksheet D-1

Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description		Title XIX		Hospital		Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Cost		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	801,978	9,232,240	0.086867	6,320,473	549,041	90.00
91.00	Nursing Program cost	0	9,232,240	0.000000	6,320,473	0	91.00
92.00	Allied health cost	0	9,232,240	0.000000	6,320,473	0	92.00
93.00	All other Medical Education	0	9,232,240	0.000000	6,320,473	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0172	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/30/2024 4:59 pm	
		Title XVIII	Hospital	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		132,640		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.111389	1,253,396	139,615	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.583021	5,338	3,112	54.00
60.00	06000 LABORATORY	1.594710	10,143	16,175	60.00
66.00	06600 PHYSICAL THERAPY	0.259668	11,681	3,033	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.285028	504,988	143,936	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.386350	672,939	259,990	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.083886	329,059	27,603	73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.219022	3,750	4,571	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,791,294	598,035	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)		2,791,294		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0172	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/30/2024 4:59 pm	
		Title XIX	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		89,040		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.111389	2,280,900	254,067	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.583021	21,900	12,768	54.00
60.00	06000 LABORATORY	1.594710	11,911	18,995	60.00
66.00	06600 PHYSICAL THERAPY	0.259668	17,063	4,431	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.285028	1,141,107	325,247	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.386350	1,016,071	392,559	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.083886	474,199	39,779	73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.219022	112,425	137,049	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		5,075,576	1,184,895	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		5,075,576		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0172	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/30/2024 4:59 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		923,160	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		0	2.04
3.00	Managed Care Simulated Payments		827,557	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		5.78	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
5.01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)		0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)		0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)		0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.80	30.00
31.00	Percentage of Medicaid patient days (see instructions)		13.96	31.00
32.00	Sum of lines 30 and 31		16.76	32.00
33.00	Allowable disproportionate share percentage (see instructions)		3.64	33.00
34.00	Disproportionate share adjustment (see instructions)		8,401	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0172	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/30/2024 4:59 pm
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Payment Adjustment				
35.00	Total uncompensated care amount (see instructions)		6,874,403,459	5,938,006,757
35.01	Factor 3 (see instructions)		0.000024709	0.000019805
35.02	Hospital UCP, including supplemental UCP (see instructions)		8,999	117,605
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)		6,731	29,562
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		36,293	
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges (see instructions)		0	
41.00	Total ESRD Medicare discharges (see instructions)		0	
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		0	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	
43.00	Total Medicare ESRD inpatient days (see instructions)		0	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	
47.00	Subtotal (see instructions)		967,854	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		967,854	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		71,600	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
55.01	Cellular therapy acquisition cost (see instructions)		0	55.01
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		1,039,454	59.00
60.00	Primary payer payments		3,835	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		1,035,619	61.00
62.00	Deductibles billed to program beneficiaries		121,556	62.00
63.00	Coinurance billed to program beneficiaries		0	63.00
64.00	Allowable bad debts (see instructions)		0	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		0	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		914,063	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)		0	70.75
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		0	70.93
70.94	HRR adjustment amount (see instructions)		-4,818	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0172	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/30/2024 4:59 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3	0	0	70.98	
70.99	HAC adjustment amount (see instructions)		0	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		909,245	71.00	
71.01	Sequestration adjustment (see instructions)		18,185	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
71.03	Sequestration adjustment-PARHM pass-throughs			71.03	
72.00	Interim payments		868,906	72.00	
72.01	Interim payments-PARHM			72.01	
73.00	Tentative settlement (for contractor use only)		0	73.00	
73.01	Tentative settlement-PARHM (for contractor use only)			73.01	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		22,154	74.00	
74.01	Balance due provider/program-PARHM (see instructions)			74.01	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		21,293	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/30/2024 4:59 pm

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	923,160	0		923,160	923,160	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	827,557	0	827,557	0	827,557	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0364	0.0364	0.0364	0.0364		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	8,401	0	0	8,401	8,401	11.00
11.01	Uncompensated care payments	36.00	36,293	0	0	29,562	29,562	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	967,854	0	0	967,854	967,854	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	967,854	0	0	967,854	967,854	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	71,600	0	0	71,600	71,600	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/30/2024 4:59 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ acquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	0	1,039,454	1,039,454
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	71,600	0	0	71,600	71,600
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	71,600	0	0	71,600	71,600
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/30/2024 4:59 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	923,160		923,160	923,160	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	827,557	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0364	0.0364	0.0364		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	8,401	0	8,401	8,401	11.00
11.01	Uncompensated care payments	36.00	36,293	0	29,562	29,562	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	967,854	0	967,854	967,854	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	967,854	0	967,854	967,854	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	71,600	0	71,600	71,600	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	1,039,454	1,039,454	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/30/2024 4:59 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	71,600	0	71,600	71,600	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	71,600	0	71,600	71,600	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-4,818	0	-4,818	-4,818	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0172	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 4:59 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		10,162,188	2.00
3.00	OPPS or REH payments		11,603,845	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		11,603,845	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,917,504	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)		9,686,341	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)		9,686,341	30.00
31.00	Primary payer payments		4,837	31.00
32.00	Subtotal (line 30 minus line 31)		9,681,504	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		9,681,504	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	ROUNDING		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)		9,681,504	40.00
40.01	Sequestration adjustment (see instructions)		193,630	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		9,487,873	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)		1	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: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet E
Part B
Date/Time Prepared:
5/30/2024 4:59 pm

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet E-1
Part I
Date/Time Prepared:
5/30/2024 4:59 pm

		Title XVIII		Hospital	PPS	
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		868,906		9,487,873	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		868,906		9,487,873	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		22,154		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		891,060		9,487,874	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: 15-0172	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/30/2024 4:59 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (see instructions)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (see instructions)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0172	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2024 4:59 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services	1,197,216			1.00
2.00	Medical and other services			3,051,151	2.00
3.00	Organ acquisition (certified transplant programs only)	0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	1,197,216		3,051,151	4.00
5.00	Inpatient primary payer payments	0			5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	1,197,216		3,051,151	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	89,040			8.00
9.00	Ancillary service charges	5,075,576		16,649,639	9.00
10.00	Organ acquisition charges, net of revenue	0			10.00
11.00	Incentive from target amount computation	0			11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	5,164,616		16,649,639	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000		0.000000	15.00
16.00	Total customary charges (see instructions)	5,164,616		16,649,639	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	3,967,400		13,598,488	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0		0	18.00
19.00	Interns and Residents (see instructions)	0		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	1,197,216		3,051,151	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments	0		0	22.00
23.00	Outlier payments	0		0	23.00
24.00	Program capital payments	0			24.00
25.00	Capital exception payments (see instructions)	0			25.00
26.00	Routine and Ancillary service other pass through costs	0		0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0		0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	1,197,216		3,051,151	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	0		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1,197,216		3,051,151	31.00
32.00	Deductibles	0		0	32.00
33.00	Coinurance	0		0	33.00
34.00	Allowable bad debts (see instructions)	0		0	34.00
35.00	Utilization review	0			35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	1,197,216		3,051,151	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		0	37.00
38.00	Subtotal (line 36 ± line 37)	1,197,216		3,051,151	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0			39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	1,197,216		3,051,151	40.00
41.00	Interim payments	0		0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	1,197,216		3,051,151	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0		0	43.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0172	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/30/2024 4:59 pm
		Title XVIII		PPS
				1.00
TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0 1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0 2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)			0 3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)			0 4.00
5.00	The rate used to calculate the time value of money (see instructions)			0.00 5.00
6.00	Time value of money for operating expenses (see instructions)			0 6.00
7.00	Time value of money for capital related expenses (see instructions)			0 7.00

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

Provider CCN: 15-0172

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

Worksheet G

Date/Time Prepared:
5/30/2024 4:59 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	4,131,369	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	21,659,819	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-15,600,411	0	0	0	6.00
7.00	Inventory	1,399,193	0	0	0	7.00
8.00	Prepaid expenses	283,616	0	0	0	8.00
9.00	Other current assets	269,735	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	12,143,321	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	1,597,916	0	0	0	17.00
18.00	Accumulated depreciation	-66,186	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	3,525,034	0	0	0	23.00
24.00	Accumulated depreciation	-305,301	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)	4,751,463	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	132,350,162	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	132,350,162	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	149,244,946	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,356,831	0	0	0	37.00
38.00	Salaries, wages, and fees payable	821,691	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,638,670	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,817,192	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	20,065,537	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	20,065,537	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25,882,729	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	123,362,217				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)	123,362,217	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	149,244,946	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0172

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

Worksheet G-1

Date/Time Prepared:
5/30/2024 4:59 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		129,311,930		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		10,902,361				2.00
3.00	Total (sum of line 1 and line 2)		140,214,291		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		140,214,291		0		11.00
12.00	EQUITY ADJS	16,852,073		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)		16,852,073		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		123,362,218		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	EQUITY ADJS		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: 15-0172

Period:
From 01/01/2023
To 12/31/2023Worksheet G-2
Parts I & II
Date/Time Prepared:
5/30/2024 4:59 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	595,602		595,602	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)	595,602		595,602	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)	595,602		595,602	17.00
18.00	Ancillary services	100,078,906	121,699,493	221,778,399	18.00
19.00	Outpatient services	2,125,945	3,058,927	5,184,872	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	102,800,453	124,758,420	227,558,873	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		48,425,517		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		48,425,517		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0172

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

Worksheet G-3

Date/Time Prepared:
5/30/2024 4:59 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	227,558,873	1.00
2.00	Less contractual allowances and discounts on patients' accounts	168,235,606	2.00
3.00	Net patient revenues (line 1 minus line 2)	59,323,267	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	48,425,517	4.00
5.00	Net income from service to patients (line 3 minus line 4)	10,897,750	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	4,611	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	4,611	25.00
26.00	Total (line 5 plus line 25)	10,902,361	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)	10,902,361	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0172	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/30/2024 4:59 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		71,600	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		1.94	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		71,600	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00