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: 15-3030	Period: From 10/01/2022 To 09/30/2023	Worksheet S Parts I-III Date/Time Prepared: 2/27/2024 7:17 am

PART I - COST REPORT STATUS

Provider use only
1. [X] Electronically prepared cost report — Date: 2/27/2024 Time: 7:17 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

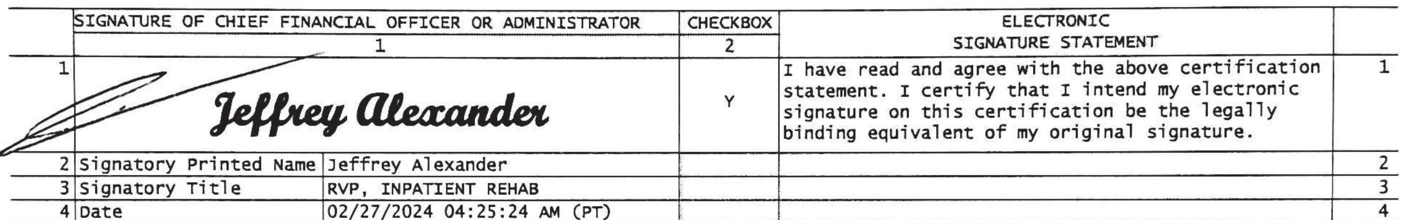
Contractor use only
5. [1] Cost Report Status
 (1) As Submitted
 (2) Settled without Audit
 (3) Settled with Audit
 (4) Reopened
 (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REHABILITATION HOSPITAL OF FT WAYNE (15-3030) for the cost reporting period beginning 10/01/2022 and ending 09/30/2023 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	Jeffrey Alexander		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	Jeffrey Alexander			2
3	Signatory Title	RVP, INPATIENT REHAB			3
4	Date	02/27/2024 04:25:24 AM (PT)			4

Encryption Information
ECR: Date: 2/27/2024 Time: 7:17 am
Suf3fhw9ed9CY7YHXYJPuSeEGRZSk0
9CyYs0m4e2KL9yjp7z9Dv7jl13Z7b7
FJqp0jWytv0v3SoU

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-105,932	0	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	-105,932	0	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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: 15-3030	Period: From 10/01/2022 To 09/30/2023	Worksheet S Parts I-III Date/Time Prepared: 2/27/2024 7:17 am

PART I - COST REPORT STATUS

Provider use only
1. [X] Electronically prepared cost report — Date: 2/27/2024 Time: 7:17 am
2. [ ] Manually prepared cost report
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4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

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

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

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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 REHABILITATION HOSPITAL OF FT WAYNE (15-3030) for the cost reporting period beginning 10/01/2022 and ending 09/30/2023 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	*Jeffrey Alexander*		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	Jeffrey Alexander			2
3	Signatory Title	RVP, INPATIENT REHAB			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-105,932	0	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	-105,932	0	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2024 7:17 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 7970 WEST JEFFERSON BOULEVARD	PO Box:			1.00
2.00	City: FORT WAYNE	State: IN	Zip Code: 46804-	County: ALLEN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	REHABILITATION HOSPITAL OF FT WAYNE	153030	23060	5	11/01/1993	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2022	09/30/2023	20.00
21.00	Type of Control (see instructions)	4		21.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	152	269	0	35	1,337		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2024 7:17 am

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

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

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

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

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

		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

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

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

		1.00	
	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

		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)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

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

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

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

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: CHS/COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 10301	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			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: 15-3030	Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part I Date/Time Prepared: 2/27/2024 7:17 am

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-3030	Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part II Date/Time Prepared: 2/27/2024 7:17 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	02/09/2024	Y	02/09/2024	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: 15-3030	Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part II Date/Time Prepared: 2/27/2024 7:17 am

		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?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2021	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	WADE	SNYDER	41.00
42.00	Enter the employer/company name of the cost report preparer.	SELECT MEDICAL CORPORATION		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	717-972-1341	WSNYDER@SELECTMEDICAL.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-3030	Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part II Date/Time Prepared: 2/27/2024 7:17 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 2/27/2024 7:17 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	36	13,140	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)		36	13,140	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)		36	13,140	0.00	0	14.00
15.00	CAH visits					0	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)	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)		36				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: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 2/27/2024 7:17 am

	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)	4,572	152	12,055			1.00
2.00	HMO and other (see instructions)	2,822	1,337				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)	4,572	152	12,055			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)	4,572	152	12,055	0.00	78.26	14.00
15.00	CAH visits	0	0	0			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)			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	78.26	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 2/27/2024 7:17 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	409	13	1,041	1.00
2.00	HMO and other (see instructions)			221	127		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	409	13	1,041	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/27/2024 7:17 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		340,975	340,975	357,242	698,217	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		383,859	383,859	-97,684	286,175	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	37,804	44,262	82,066	1,523,399	1,605,465	4.00
5.01	00570	ADMITTING	160,607	260,217	420,824	-110	420,714	5.01
5.02	00590	ADMIN AND GENERAL - OTHER	1,422,205	3,692,155	5,114,360	-2,041,782	3,072,578	5.02
7.00	00700	OPERATION OF PLANT	327,671	686,667	1,014,338	66,577	1,080,915	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	74,345	74,345	0	74,345	8.00
9.00	00900	HOUSEKEEPING	222,577	50,389	272,966	-507	272,459	9.00
10.00	01000	DIETARY	374,405	326,348	700,753	-154,699	546,054	10.00
11.00	01100	CAFETERIA	0	0	0	131,220	131,220	11.00
13.00	01300	NURSING ADMINISTRATION	426,642	57,605	484,247	-1,050	483,197	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,206	79,559	90,765	-50,314	40,451	14.00
15.00	01500	PHARMACY	191,640	354,755	546,395	-326,217	220,178	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	96,075	96,075	-72	96,003	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,616,833	1,400,455	5,017,288	288,844	5,306,132	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	101,076	101,076	0	101,076	54.00
60.00	06000	LABORATORY	49,414	46,909	96,323	0	96,323	60.00
65.00	06500	RESPIRATORY THERAPY	28,074	19,407	47,481	-7,634	39,847	65.00
66.00	06600	PHYSICAL THERAPY	1,224,799	136,461	1,361,260	-11,273	1,349,987	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,084,294	101,541	1,185,835	0	1,185,835	67.00
68.00	06800	SPEECH PATHOLOGY	315,704	37,925	353,629	0	353,629	68.00
69.00	06900	ELECTROCARDIOLOGY	0	570	570	0	570	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,769	44,189	49,958	-18,813	31,145	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,047	97,045	146,092	323,817	469,909	73.00
76.00	03550	PSYCH SERVICES	43,967	4,776	48,743	-6,456	42,287	76.00
76.01	03950	SLEEP LAB	63,525	85,006	148,531	-7,523	141,008	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,530	59,213	69,743	0	69,743	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,666,713	8,581,784	18,248,497	-33,035	18,215,462	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	348	3,736	4,084	-575	3,509	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	33,610	33,610	194.01
194.02	07952	TENANT LEASED SPACE	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	9,667,061	8,585,520	18,252,581	0	18,252,581	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/27/2024 7:17 am

		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	51,363	749,580	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	20,276	306,451	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,605,465	4.00
5.01	00570	ADMITTING	0	420,714	5.01
5.02	00590	ADMIN AND GENERAL - OTHER	-80,821	2,991,757	5.02
7.00	00700	OPERATION OF PLANT	-6,816	1,074,099	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	74,345	8.00
9.00	00900	HOUSEKEEPING	0	272,459	9.00
10.00	01000	DIETARY	0	546,054	10.00
11.00	01100	CAFETERIA	-52,894	78,326	11.00
13.00	01300	NURSING ADMINISTRATION	0	483,197	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	40,451	14.00
15.00	01500	PHARMACY	0	220,178	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-64	95,939	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-201,502	5,104,630	30.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	101,076	54.00
60.00	06000	LABORATORY	0	96,323	60.00
65.00	06500	RESPIRATORY THERAPY	0	39,847	65.00
66.00	06600	PHYSICAL THERAPY	0	1,349,987	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,185,835	67.00
68.00	06800	SPEECH PATHOLOGY	0	353,629	68.00
69.00	06900	ELECTROCARDIOLOGY	0	570	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	31,145	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	469,909	73.00
76.00	03550	PSYCH SERVICES	0	42,287	76.00
76.01	03950	SLEEP LAB	0	141,008	76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	69,743	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-270,458	17,945,004	118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,509	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	33,610	194.01
194.02	07952	TENANT LEASED SPACE	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-270,458	17,982,123	200.00

RECLASSIFICATIONS | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/27/2024 7:17 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,523,572	1.00
	TOTALS		0	1,523,572	
	B - RENTAL AND LEASE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,430	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	76,284	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	TOTALS		0	82,714	
	C - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	39,057	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	137,787	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	176,844	
	D - REPAIRS & MAINTENANCE COSTS				
1.00	OPERATION OF PLANT	7.00	0	68,670	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
	TOTALS		0	68,670	
	E - MEDICAL SUPPLIES				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	18,813	1.00
	TOTALS		0	18,813	
	F - DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	323,817	1.00
	TOTALS		0	323,817	
	G - MISC DEPARTMENTS				
1.00	ADULTS & PEDIATRICS	30.00	0	294,542	1.00
	TOTALS		0	294,542	
	H - DIETARY RECLASS TO CAFETERIA				
1.00	CAFETERIA	11.00	69,453	56,408	1.00
	TOTALS		69,453	56,408	
	I - SELECT RECLASS FACILITY RENT				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	173,968	1.00
	TOTALS		0	173,968	
	J - SELECT PROVIDER RELATIONS TO NRCC				
1.00	MARKETING/PUBLIC RELATIONS	194.01	24,399	9,211	1.00
	TOTALS		24,399	9,211	
	L - SELECT DIETARY RECLASS TO CAFETERIA				
1.00	CAFETERIA	11.00	0	5,359	1.00
	TOTALS		0	5,359	
500.00	Grand Total: Increases		93,852	2,733,918	500.00

RECLASSIFICATIONS | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6

Date/Time Prepared: 2/27/2024 7:17 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - EMPLOYEE BENEFITS					
1.00	ADMIN AND GENERAL - OTHER	5.02	0	1,523,572	0	1.00
	TOTALS		0	1,523,572		
	B - RENTAL AND LEASE					
1.00		0.00	0	0	12	1.00
2.00		0.00	0	0	12	2.00
3.00	ADMIN AND GENERAL - OTHER	5.02	0	2,097	0	3.00
4.00	OPERATION OF PLANT	7.00	0	2,093	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	33	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	59,657	0	6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	72	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	55	0	8.00
9.00	RESPIRATORY THERAPY	65.00	0	7,080	0	9.00
10.00	PHYSICAL THERAPY	66.00	0	4,852	0	10.00
11.00	PSYCH SERVICES	76.00	0	6,456	0	11.00
12.00	SLEEP LAB	76.01	0	23	0	12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	13	0	13.00
14.00	ADMITTING	5.01	0	110	0	14.00
15.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	173	0	15.00
	TOTALS		0	82,714		
	C - OTHER CAPITAL COSTS					
1.00		0.00	0	0	12	1.00
2.00		0.00	0	0	13	2.00
3.00	ADMIN AND GENERAL - OTHER	5.02	0	176,844	0	3.00
	TOTALS		0	176,844		
	D - REPAIRS & MAINTENANCE COSTS					
1.00	ADMIN AND GENERAL - OTHER	5.02	0	11,117	0	1.00
2.00	HOUSEKEEPING	9.00	0	507	0	2.00
3.00	DIETARY	10.00	0	23,479	0	3.00
4.00	NURSING ADMINISTRATION	13.00	0	1,017	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	9,470	0	5.00
6.00	PHARMACY	15.00	0	2,400	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	5,643	0	7.00
8.00	RESPIRATORY THERAPY	65.00	0	554	0	8.00
9.00	PHYSICAL THERAPY	66.00	0	6,421	0	9.00
10.00	SLEEP LAB	76.01	0	7,500	0	10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	562	0	11.00
	TOTALS		0	68,670		
	E - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	18,813	0	1.00
	TOTALS		0	18,813		
	F - DRUGS CHARGED TO PATIENTS					
1.00	PHARMACY	15.00	0	323,817	0	1.00
	TOTALS		0	323,817		
	G - MISC DEPARTMENTS					
1.00	ADMIN AND GENERAL - OTHER	5.02	0	294,542	0	1.00
	TOTALS		0	294,542		
	H - DIETARY RECLASS TO CAFETERIA					
1.00	DIETARY	10.00	69,453	56,408	0	1.00
	TOTALS		69,453	56,408		
	I - SELECT RECLASS FACILITY RENT					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	173,968	10	1.00
	TOTALS		0	173,968		
	J - SELECT PROVIDER RELATIONS TO NRCC					
1.00	ADMIN AND GENERAL - OTHER	5.02	24,399	9,211	0	1.00
	TOTALS		24,399	9,211		
	L - SELECT DIETARY RECLASS TO CAFETERIA					
1.00	DIETARY	10.00	0	5,359	0	1.00
	TOTALS		0	5,359		
500.00	Grand Total: Decreases		93,852	2,733,918		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part I Date/Time Prepared: 2/27/2024 7:17 am

		Beginning Balances	Acquisitions Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	900,000	0	0	0	900,000	1.00
2.00	Land Improvements	284,574	0	0	0	284,574	2.00
3.00	Buildings and Fixtures	11,662,532	0	0	0	11,662,532	3.00
4.00	Building Improvements	1,453,458	0	0	0	980,912	4.00
5.00	Fixed Equipment	654,587	0	0	0	654,587	5.00
6.00	Movable Equipment	1,102,722	290,288	0	290,288	0	6.00
7.00	HIT designated Assets	541,232	0	0	0	541,232	7.00
8.00	Subtotal (sum of lines 1-7)	16,599,105	290,288	0	290,288	15,023,837	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	16,599,105	290,288	0	290,288	15,023,837	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	472,546	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	1,393,010	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	1,865,556	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	1,865,556	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part II Date/Time Prepared: 2/27/2024 7:17 am

	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	340,975	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	383,859	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	724,834	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	340,975	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	383,859	2.00
3.00	Total (sum of lines 1-2)	0	724,834	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part III | Date/Time Prepared: 2/27/2024 7:17 am

	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	340,975	0	340,975	0.470418	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	383,859	0	383,859	0.529582	0	2.00
3.00	Total (sum of lines 1-2)	724,834	0	724,834	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	347,423	173,968	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	404,135	-173,968	2.00
3.00	Total (sum of lines 1-2)	0	0	0	751,558	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	44,915	45,487	137,787	0	749,580	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	76,284	0	0	306,451	2.00
3.00	Total (sum of lines 1-2)	44,915	121,771	137,787	0	1,056,031	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/27/2024 7:17 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	0	ADMIN AND GENERAL - OTHER	5.02	0	7.00
8.00	Television and radio service (chapter 21)	A	-6,816	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-201,502			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	479,004			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-52,894	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-8,225	CAP REL COSTS-BLDG & FIXT	1.00	9	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-64	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,345	ADMIN AND GENERAL - OTHER	5.02	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELANEOUS INCOME	B	-336	ADMIN AND GENERAL - OTHER	5.02	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/27/2024 7:17 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MARKETING EXPENSE - EXCLUDING MARKET	A	-469,730	ADMIN AND GENERAL - OTHER	5.02	0	33.01
33.02	PATIENT TELEPHONE EXPENSE	A	0	ADMIN AND GENERAL - OTHER	5.02	0	33.02
33.03	PATIENT TV CABLE EXPENSE	A	0	OPERATION OF PLANT	7.00	0	33.03
33.04	PHYSICIAN RECRUITING EXPENSE	A	-8,357	ADMIN AND GENERAL - OTHER	5.02	0	33.04
33.05	LOBBYING FEES SXPENSE	A	0	ADMIN AND GENERAL - OTHER	5.02	0	33.05
33.06	CHARITABLE CONTRIBUTIONS	A	-39	ADMIN AND GENERAL - OTHER	5.02	0	33.06
33.07	SELECT OTHER PERSONNEL EXPENSE	A	-154	ADMIN AND GENERAL - OTHER	5.02	0	33.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-270,458				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: 15-3030	Period: From 10/01/2022 To 09/30/2023	Worksheet A-8-1 Date/Time Prepared: 2/27/2024 7:17 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	SELECT HOME OFFICE ALLOCATIO	5,600	0	1.00
2.00	5.02	ADMIN AND GENERAL - OTHER	SELECT HOME OFFICE ALLOCATIO	138,453	106,396	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	LUTHERAN HOCR DIRECT CAPITAL	39,315	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	LUTHERAN HOCR PASI CAPITAL B	15	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	LUTHERAN HOCR PASI CAPITAL M	31	0	4.01
4.02	5.02	ADMIN AND GENERAL - OTHER	LUTHERAN HOCR PASI OPERATING	9,220	9,450	4.02
4.03	5.02	ADMIN AND GENERAL - OTHER	LUTHERAN HOCR SHARED SVCS AL	316,595	91,840	4.03
4.04	1.00	CAP REL COSTS-BLDG & FIXT	LUTHERAN HOCR NEW CAPITAL BL	14,658	0	4.04
4.05	2.00	CAP REL COSTS-MVBLE EQUIP	LUTHERAN HOCR NEW CAPITAL MO	20,245	0	4.05
4.06	5.02	ADMIN AND GENERAL - OTHER	LUTHERAN HOCR NON CAPITAL AL	549,227	0	4.06
4.07	5.02	ADMIN AND GENERAL - OTHER	MALPRACTICE COSTS	-168,463	87,083	4.07
4.08	5.02	ADMIN AND GENERAL - OTHER	HIIM ALLOCATION	0	63,939	4.08
4.09	5.02	ADMIN AND GENERAL - OTHER	CONTRACT MANAGEMENT	0	85,856	4.09
4.10	5.02	ADMIN AND GENERAL - OTHER	PASI LIEN UNIT COLLECTION FE	0	1,328	4.10
4.11	0.00			0	0	4.11
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			924,896	445,892	5.00

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

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		0.00	INTENSIVA HEALT	70.00	6.00
7.00	B		0.00	LUTHERAN	30.00	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
10.01			0.00		0.00	10.01
100.00	G. Other (financial or non-financial) specify:	NON-FINANCIAL				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: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 2/27/2024 7:17 am

	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	5,600	11	1.00
2.00	32,057	0	2.00
3.00	39,315	11	3.00
4.00	15	9	4.00
4.01	31	9	4.01
4.02	-230	0	4.02
4.03	224,755	0	4.03
4.04	14,658	9	4.04
4.05	20,245	9	4.05
4.06	549,227	0	4.06
4.07	-255,546	0	4.07
4.08	-63,939	0	4.08
4.09	-85,856	0	4.09
4.10	-1,328	0	4.10
4.11	0	0	4.11
5.00	479,004		5.00

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

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

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

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

	Type of Business		
6.00	HEALTHCARE		6.00
7.00	HEALTHCARE		7.00
8.00			8.00
9.00			9.00
10.00			10.00
10.01			10.01
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 2/27/2024 7:17 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	294,542	94,051	200,491	211,500	915	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			294,542	94,051	200,491		915	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	93,040	4,652	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			93,040	4,652	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	93,040	107,451	201,502		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	93,040	107,451	201,502		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/27/2024 7:17 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	749,580	749,580				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	306,451		306,451			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,605,465	3,024	1,236	1,609,725		4.00
5.01	00570	ADMITTING	420,714	15,575	6,368	26,849	469,506	5.01
5.02	00590	ADMIN AND GENERAL - OTHER	2,991,757	58,994	24,119	233,671	0	5.02
7.00	00700	OPERATION OF PLANT	1,074,099	0	0	54,777	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	74,345	137,315	56,139	0	0	8.00
9.00	00900	HOUSEKEEPING	272,459	0	0	37,208	0	9.00
10.00	01000	DIETARY	546,054	14,835	6,065	50,979	0	10.00
11.00	01100	CAFETERIA	78,326	0	0	11,610	0	11.00
13.00	01300	NURSING ADMINISTRATION	483,197	57,315	23,432	71,322	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	40,451	1,604	656	1,873	0	14.00
15.00	01500	PHARMACY	220,178	11,330	4,632	32,036	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	95,939	4,801	1,963	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	5,504	2,250	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,104,630	99,006	40,477	604,630	184,442	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	101,076	5,307	2,170	0	7,098	54.00
60.00	06000	LABORATORY	96,323	0	0	8,261	25,425	60.00
65.00	06500	RESPIRATORY THERAPY	39,847	1,234	505	4,693	1,670	65.00
66.00	06600	PHYSICAL THERAPY	1,349,987	124,541	50,916	204,750	78,425	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,185,835	58,796	24,038	181,261	79,757	67.00
68.00	06800	SPEECH PATHOLOGY	353,629	4,455	1,822	52,776	14,321	68.00
69.00	06900	ELECTROCARDIOLOGY	570	0	0	0	93	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	31,145	0	0	964	967	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	469,909	0	0	8,199	67,892	73.00
76.00	03550	PSYCH SERVICES	42,287	0	0	7,350	2,236	76.00
76.01	03950	SLEEP LAB	141,008	5,085	2,079	10,619	7,180	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	69,743	0	0	1,760	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,945,004	608,721	248,867	1,605,588	469,506	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,509	0	0	58	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	33,610	0	0	4,079	0	194.01
194.02	07952	TENANT LEASED SPACE	0	140,859	57,584	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,982,123	749,580	306,451	1,609,725	469,506	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/27/2024 7:17 am

		Cost Center Description	Subtotal	ADMIN AND GENERAL - OTHER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.01	5.02	7.00	8.00	9.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00590	ADMIN AND GENERAL - OTHER	3,308,541	3,308,541				5.02
7.00	00700	OPERATION OF PLANT	1,128,876	254,534	1,383,410			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	267,799	60,382	0	328,181		8.00
9.00	00900	HOUSEKEEPING	309,667	69,822	38,384	0	417,873	9.00
10.00	01000	DIETARY	617,933	139,329	0	0	0	10.00
11.00	01100	CAFETERIA	89,936	20,278	148,298	0	63,197	11.00
13.00	01300	NURSING ADMINISTRATION	635,266	143,237	4,151	0	1,769	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	44,584	10,053	29,315	0	12,493	14.00
15.00	01500	PHARMACY	268,176	60,467	12,422	0	5,294	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	102,703	23,157	14,242	0	6,069	16.00
17.00	01700	SOCIAL SERVICE	7,754	1,748	9,229	0	3,933	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,033,185	1,360,342	246,939	184,086	105,234	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	115,651	26,077	13,731	0	5,852	54.00
60.00	06000	LABORATORY	130,009	29,314	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	47,949	10,811	3,193	0	1,361	65.00
66.00	06600	PHYSICAL THERAPY	1,808,619	407,800	322,238	68,337	137,321	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,529,687	344,908	152,130	75,758	64,830	67.00
68.00	06800	SPEECH PATHOLOGY	427,003	96,279	11,528	0	4,913	68.00
69.00	06900	ELECTROCARDIOLOGY	663	149	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	33,076	7,458	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	546,000	123,110	0	0	0	73.00
76.00	03550	PSYCH SERVICES	51,873	11,696	13,156	0	5,607	76.00
76.01	03950	SLEEP LAB	165,971	37,422	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	71,503	16,122	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,742,424	3,254,495	1,018,956	328,181	417,873	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,567	804	0	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	37,689	8,498	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	198,443	44,744	364,454	0	0	194.02
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,982,123	3,308,541	1,383,410	328,181	417,873	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/27/2024 7:17 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00590	ADMIN AND GENERAL - OTHER						5.02
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	757,262					10.00
11.00	01100	CAFETERIA	0	321,709				11.00
13.00	01300	NURSING ADMINISTRATION	0	21,959	806,382			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	927	0	97,372		14.00
15.00	01500	PHARMACY	0	9,694	0	6	356,059	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	548	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	757,262	167,914	806,382	79,613	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	5,226	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	506	0	2,316	0	65.00
66.00	06600	PHYSICAL THERAPY	0	47,626	0	5,667	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	50,661	0	2,072	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	11,759	0	1,145	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,542	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	356,059	73.00
76.00	03550	PSYCH SERVICES	0	1,433	0	0	0	76.00
76.01	03950	SLEEP LAB	0	2,950	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	464	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	757,262	321,667	806,382	97,361	356,059	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	42	0	11	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	757,262	321,709	806,382	97,372	356,059	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/27/2024 7:17 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
	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
5.01	00570	ADMITTING						5.01
5.02	00590	ADMIN AND GENERAL - OTHER						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	146,719					16.00
17.00	01700	SOCIAL SERVICE	0	22,664				17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	57,616	22,664	9,821,237	0	9,821,237	30.00
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,219	0	163,530	0	163,530	54.00
60.00	06000	LABORATORY	7,947	0	172,496	0	172,496	60.00
65.00	06500	RESPIRATORY THERAPY	522	0	66,658	0	66,658	65.00
66.00	06600	PHYSICAL THERAPY	24,514	0	2,822,122	0	2,822,122	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,930	0	2,244,976	0	2,244,976	67.00
68.00	06800	SPEECH PATHOLOGY	4,476	0	557,103	0	557,103	68.00
69.00	06900	ELECTROCARDIOLOGY	29	0	841	0	841	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	302	0	47,378	0	47,378	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,221	0	1,046,390	0	1,046,390	73.00
76.00	03550	PSYCH SERVICES	699	0	84,464	0	84,464	76.00
76.01	03950	SLEEP LAB	2,244	0	208,587	0	208,587	76.01
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	88,089	0	88,089	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	146,719	22,664	17,323,871	0	17,323,871	118.00
	NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,424	0	4,424	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	46,187	0	46,187	194.01
194.02	07952	TENANT LEASED SPACE	0	0	607,641	0	607,641	194.02
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	146,719	22,664	17,982,123	0	17,982,123	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/27/2024 7:17 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,024	1,236	4,260	4,260	4.00
5.01	00570	ADMITTING	0	15,575	6,368	21,943	71	5.01
5.02	00590	ADMIN AND GENERAL - OTHER	0	58,994	24,119	83,113	618	5.02
7.00	00700	OPERATION OF PLANT	0	0	0	0	145	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	137,315	56,139	193,454	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	98	9.00
10.00	01000	DIETARY	0	14,835	6,065	20,900	135	10.00
11.00	01100	CAFETERIA	0	0	0	0	31	11.00
13.00	01300	NURSING ADMINISTRATION	0	57,315	23,432	80,747	189	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,604	656	2,260	5	14.00
15.00	01500	PHARMACY	0	11,330	4,632	15,962	85	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,801	1,963	6,764	0	16.00
17.00	01700	SOCIAL SERVICE	0	5,504	2,250	7,754	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	99,006	40,477	139,483	1,601	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,307	2,170	7,477	0	54.00
60.00	06000	LABORATORY	0	0	0	0	22	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,234	505	1,739	12	65.00
66.00	06600	PHYSICAL THERAPY	0	124,541	50,916	175,457	541	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	58,796	24,038	82,834	479	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,455	1,822	6,277	140	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	3	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	22	73.00
76.00	03550	PSYCH SERVICES	0	0	0	0	19	76.00
76.01	03950	SLEEP LAB	0	5,085	2,079	7,164	28	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	5	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	608,721	248,867	857,588	4,249	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	11	194.01
194.02	07952	TENANT LEASED SPACE	0	140,859	57,584	198,443	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	749,580	306,451	1,056,031	4,260	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/27/2024 7:17 am

		Cost Center Description	ADMITTING	ADMIN AND GENERAL - OTHER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		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
5.01	00570	ADMITTING	22,014					5.01
5.02	00590	ADMIN AND GENERAL - OTHER	0	83,731				5.02
7.00	00700	OPERATION OF PLANT	0	6,441	6,586			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,528	0	194,982		8.00
9.00	00900	HOUSEKEEPING	0	1,767	183	0	2,048	9.00
10.00	01000	DIETARY	0	3,526	0	0	0	10.00
11.00	01100	CAFETERIA	0	513	706	0	310	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,625	20	0	9	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	254	140	0	61	14.00
15.00	01500	PHARMACY	0	1,530	59	0	26	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	586	68	0	30	16.00
17.00	01700	SOCIAL SERVICE	0	44	44	0	19	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,637	34,431	1,176	109,371	516	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	333	660	65	0	29	54.00
60.00	06000	LABORATORY	1,193	742	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	78	274	15	0	7	65.00
66.00	06600	PHYSICAL THERAPY	3,681	10,320	1,534	40,601	672	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,743	8,728	724	45,010	318	67.00
68.00	06800	SPEECH PATHOLOGY	672	2,436	55	0	24	68.00
69.00	06900	ELECTROCARDIOLOGY	4	4	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	45	189	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,186	3,115	0	0	0	73.00
76.00	03550	PSYCH SERVICES	105	296	63	0	27	76.00
76.01	03950	SLEEP LAB	337	947	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	408	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,014	82,364	4,852	194,982	2,048	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	20	0	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	215	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	1,132	1,734	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	22,014	83,731	6,586	194,982	2,048	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/27/2024 7:17 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00590	ADMIN AND GENERAL - OTHER						5.02
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	24,561					10.00
11.00	01100	CAFETERIA	0	1,560				11.00
13.00	01300	NURSING ADMINISTRATION	0	106	84,696			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4	0	2,724		14.00
15.00	01500	PHARMACY	0	47	0	0	17,709	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,561	816	84,696	2,227	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	25	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2	0	65	0	65.00
66.00	06600	PHYSICAL THERAPY	0	231	0	159	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	246	0	58	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	57	0	32	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	183	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	17,709	73.00
76.00	03550	PSYCH SERVICES	0	7	0	0	0	76.00
76.01	03950	SLEEP LAB	0	14	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,561	1,560	84,696	2,724	17,709	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	24,561	1,560	84,696	2,724	17,709	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/27/2024 7:17 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00590	ADMIN AND GENERAL - OTHER						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,451					16.00
17.00	01700	SOCIAL SERVICE	0	7,861				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,907	7,861	418,283	0	418,283	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	113	0	8,677	0	8,677	54.00
60.00	06000	LABORATORY	405	0	2,387	0	2,387	60.00
65.00	06500	RESPIRATORY THERAPY	27	0	2,219	0	2,219	65.00
66.00	06600	PHYSICAL THERAPY	1,250	0	234,446	0	234,446	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,272	0	143,412	0	143,412	67.00
68.00	06800	SPEECH PATHOLOGY	228	0	9,921	0	9,921	68.00
69.00	06900	ELECTROCARDIOLOGY	1	0	9	0	9	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15	0	435	0	435	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,083	0	25,115	0	25,115	73.00
76.00	03550	PSYCH SERVICES	36	0	553	0	553	76.00
76.01	03950	SLEEP LAB	114	0	8,604	0	8,604	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	415	0	415	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,451	7,861	854,476	0	854,476	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	20	0	20	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	226	0	226	194.01
194.02	07952	TENANT LEASED SPACE	0	0	201,309	0	201,309	194.02
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,451	7,861	1,056,031	0	1,056,031	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/27/2024 7:17 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	
			1.00	2.00	4.00	5.01	5A.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	728,820					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		728,820				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,940	2,940	9,629,257			4.00
5.01	00570	ADMITTING	15,144	15,144	160,607	70,621,686		5.01
5.02	00590	ADMIN AND GENERAL - OTHER	57,360	57,360	1,397,806	0	-3,308,541	5.02
7.00	00700	OPERATION OF PLANT	0	0	327,671	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	133,512	133,512	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	222,577	0	0	9.00
10.00	01000	DIETARY	14,424	14,424	304,952	0	0	10.00
11.00	01100	CAFETERIA	0	0	69,453	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	55,728	55,728	426,642	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,560	1,560	11,206	0	0	14.00
15.00	01500	PHARMACY	11,016	11,016	191,640	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,668	4,668	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	5,352	5,352	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	96,264	96,264	3,616,833	27,741,919	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,160	5,160	0	1,067,739	0	54.00
60.00	06000	LABORATORY	0	0	49,414	3,824,442	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,200	1,200	28,074	251,204	0	65.00
66.00	06600	PHYSICAL THERAPY	121,092	121,092	1,224,799	11,796,802	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	57,168	57,168	1,084,294	11,997,172	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,332	4,332	315,704	2,154,180	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,034	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	5,769	145,495	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	49,047	10,212,359	0	73.00
76.00	03550	PSYCH SERVICES	0	0	43,967	336,318	0	76.00
76.01	03950	SLEEP LAB	4,944	4,944	63,525	1,080,022	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	10,530	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	591,864	591,864	9,604,510	70,621,686	-3,308,541	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	348	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	24,399	0	0	194.01
194.02	07952	TENANT LEASED SPACE	136,956	136,956	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	749,580	306,451	1,609,725	469,506		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.028484	0.420476	0.167170	0.006648		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			4,260	22,014		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000442	0.000312		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: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/27/2024 7:17 am

		Cost Center Description	ADMIN AND GENERAL - OTHER (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUN)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			5.02	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
5.01	00570	ADMITTING						5.01
5.02	00590	ADMIN AND GENERAL - OTHER	14,673,582					5.02
7.00	00700	OPERATION OF PLANT	1,128,876	519,864				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	267,799	0	100,480			8.00
9.00	00900	HOUSEKEEPING	309,667	14,424	0	368,484		9.00
10.00	01000	DIETARY	617,933	0	0	0	66,982	10.00
11.00	01100	CAFETERIA	89,936	55,728	0	55,728	0	11.00
13.00	01300	NURSING ADMINISTRATION	635,266	1,560	0	1,560	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	44,584	11,016	0	11,016	0	14.00
15.00	01500	PHARMACY	268,176	4,668	0	4,668	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	102,703	5,352	0	5,352	0	16.00
17.00	01700	SOCIAL SERVICE	7,754	3,468	0	3,468	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,033,185	92,796	56,362	92,796	66,982	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	115,651	5,160	0	5,160	0	54.00
60.00	06000	LABORATORY	130,009	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	47,949	1,200	0	1,200	0	65.00
66.00	06600	PHYSICAL THERAPY	1,808,619	121,092	20,923	121,092	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,529,687	57,168	23,195	57,168	0	67.00
68.00	06800	SPEECH PATHOLOGY	427,003	4,332	0	4,332	0	68.00
69.00	06900	ELECTROCARDIOLOGY	663	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	33,076	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	546,000	0	0	0	0	73.00
76.00	03550	PSYCH SERVICES	51,873	4,944	0	4,944	0	76.00
76.01	03950	SLEEP LAB	165,971	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	71,503	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,433,883	382,908	100,480	368,484	66,982	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,567	0	0	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	37,689	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	198,443	136,956	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,308,541	1,383,410	328,181	417,873	757,262	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.225476	2.661100	3.266133	1.134033	11.305455	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	83,731	6,586	194,982	2,048	24,561	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.005706	0.012669	1.940506	0.005558	0.366681	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: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/27/2024 7:17 am

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING SA LARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMIN AND GENERAL - OTHER						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	7,633					11.00
13.00	01300	NURSING ADMINISTRATION	521	2,899,034				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	22	0	277,963			14.00
15.00	01500	PHARMACY	230	0	16	511,219		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13	0	0	0	70,621,686	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,984	2,899,034	227,268	0	27,741,919	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	1,067,739	54.00
60.00	06000	LABORATORY	124	0	0	0	3,824,442	60.00
65.00	06500	RESPIRATORY THERAPY	12	0	6,610	0	251,204	65.00
66.00	06600	PHYSICAL THERAPY	1,130	0	16,177	0	11,796,802	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,202	0	5,916	0	11,997,172	67.00
68.00	06800	SPEECH PATHOLOGY	279	0	3,268	0	2,154,180	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	14,034	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	18,676	0	145,495	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	511,219	10,212,359	73.00
76.00	03550	PSYCH SERVICES	34	0	0	0	336,318	76.00
76.01	03950	SLEEP LAB	70	0	0	0	1,080,022	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,632	2,899,034	277,931	511,219	70,621,686	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1	0	32	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	321,709	806,382	97,372	356,059	146,719	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	42.147124	0.278155	0.350306	0.696490	0.002078	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,560	84,696	2,724	17,709	7,451	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.204376	0.029215	0.009800	0.034641	0.000106	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: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/27/2024 7:17 am

		Cost Center Description	SOCIAL SERVICE (PATIENT DA YS %)	
			17.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00570	ADMITTING		5.01
5.02	00590	ADMIN AND GENERAL - OTHER		5.02
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	11,158	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	11,158	30.00
		ANCILLARY SERVICE COST CENTERS		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03550	PSYCH SERVICES	0	76.00
76.01	03950	SLEEP LAB	0	76.01
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,158	118.00
		NONREIMBURSABLE COST CENTERS		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	194.01
194.02	07952	TENANT LEASED SPACE	0	194.02
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	22,664	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.031188	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,861	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.704517	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: 15-3030

Period: From 10/01/2022 To 09/30/2023

Worksheet C Part I

Date/Time Prepared: 2/27/2024 7:17 am

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	9,821,237		9,821,237	107,451	9,928,688	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	163,530		163,530	0	163,530	54.00
60.00	06000	LABORATORY	172,496		172,496	0	172,496	60.00
65.00	06500	RESPIRATORY THERAPY	66,658	0	66,658	0	66,658	65.00
66.00	06600	PHYSICAL THERAPY	2,822,122	0	2,822,122	0	2,822,122	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,244,976	0	2,244,976	0	2,244,976	67.00
68.00	06800	SPEECH PATHOLOGY	557,103	0	557,103	0	557,103	68.00
69.00	06900	ELECTROCARDIOLOGY	841		841	0	841	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,378		47,378	0	47,378	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,046,390		1,046,390	0	1,046,390	73.00
76.00	03550	PSYCH SERVICES	84,464		84,464	0	84,464	76.00
76.01	03950	SLEEP LAB	208,587		208,587	0	208,587	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	88,089		88,089	0	88,089	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Subtotal (see instructions)	17,323,871	0	17,323,871	107,451	17,431,322	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	17,323,871	0	17,323,871	107,451	17,431,322	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I | Date/Time Prepared: 2/27/2024 7:17 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,738,373		27,738,373			30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,067,739	0	1,067,739	0.153155	0.000000	54.00
60.00	06000	LABORATORY	3,824,442	0	3,824,442	0.045104	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	251,204	0	251,204	0.265354	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	11,796,802	0	11,796,802	0.239228	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,997,172	0	11,997,172	0.187125	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,154,180	0	2,154,180	0.258615	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	14,034	0	14,034	0.059926	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	145,495	0	145,495	0.325633	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,212,359	0	10,212,359	0.102463	0.000000	73.00
76.00	03550	PSYCH SERVICES	336,318	0	336,318	0.251143	0.000000	76.00
76.01	03950	SLEEP LAB	1,080,022	0	1,080,022	0.193132	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,546	0	3,546	0.000000	0.000000	92.00
200.00		Subtotal (see instructions)	70,621,686	0	70,621,686			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	70,621,686	0	70,621,686			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-3030

Period: From 10/01/2022 To 09/30/2023

Worksheet C Part I

Date/Time Prepared: 2/27/2024 7:17 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.153155	54.00
60.00	06000	LABORATORY	0.045104	60.00
65.00	06500	RESPIRATORY THERAPY	0.265354	65.00
66.00	06600	PHYSICAL THERAPY	0.239228	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.187125	67.00
68.00	06800	SPEECH PATHOLOGY	0.258615	68.00
69.00	06900	ELECTROCARDIOLOGY	0.059926	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.325633	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.102463	73.00
76.00	03550	PSYCH SERVICES	0.251143	76.00
76.01	03950	SLEEP LAB	0.193132	76.01
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
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: 15-3030

Period: From 10/01/2022 To 09/30/2023

Worksheet C Part I

Date/Time Prepared: 2/27/2024 7:17 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,821,237		9,821,237	107,451	9,928,688	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	163,530		163,530	0	163,530	54.00
60.00	06000	LABORATORY	172,496		172,496	0	172,496	60.00
65.00	06500	RESPIRATORY THERAPY	66,658	0	66,658	0	66,658	65.00
66.00	06600	PHYSICAL THERAPY	2,822,122	0	2,822,122	0	2,822,122	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,244,976	0	2,244,976	0	2,244,976	67.00
68.00	06800	SPEECH PATHOLOGY	557,103	0	557,103	0	557,103	68.00
69.00	06900	ELECTROCARDIOLOGY	841		841	0	841	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,378		47,378	0	47,378	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,046,390		1,046,390	0	1,046,390	73.00
76.00	03550	PSYCH SERVICES	84,464		84,464	0	84,464	76.00
76.01	03950	SLEEP LAB	208,587		208,587	0	208,587	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	88,089		88,089	0	88,089	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Subtotal (see instructions)	17,323,871	0	17,323,871	107,451	17,431,322	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	17,323,871	0	17,323,871	107,451	17,431,322	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-3030

Period: From 10/01/2022 To 09/30/2023

Worksheet C Part I

Date/Time Prepared: 2/27/2024 7:17 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,738,373		27,738,373			30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,067,739	0	1,067,739	0.153155	0.000000	54.00
60.00	06000	LABORATORY	3,824,442	0	3,824,442	0.045104	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	251,204	0	251,204	0.265354	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	11,796,802	0	11,796,802	0.239228	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,997,172	0	11,997,172	0.187125	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,154,180	0	2,154,180	0.258615	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	14,034	0	14,034	0.059926	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	145,495	0	145,495	0.325633	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,212,359	0	10,212,359	0.102463	0.000000	73.00
76.00	03550	PSYCH SERVICES	336,318	0	336,318	0.251143	0.000000	76.00
76.01	03950	SLEEP LAB	1,080,022	0	1,080,022	0.193132	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,546	0	3,546	0.000000	0.000000	92.00
200.00		Subtotal (see instructions)	70,621,686	0	70,621,686			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	70,621,686	0	70,621,686			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-3030

Period: From 10/01/2022 To 09/30/2023

Worksheet C Part I

Date/Time Prepared: 2/27/2024 7:17 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.153155	54.00
60.00	06000	LABORATORY	0.045104	60.00
65.00	06500	RESPIRATORY THERAPY	0.265354	65.00
66.00	06600	PHYSICAL THERAPY	0.239228	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.187125	67.00
68.00	06800	SPEECH PATHOLOGY	0.258615	68.00
69.00	06900	ELECTROCARDIOLOGY	0.059926	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.325633	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.102463	73.00
76.00	03550	PSYCH SERVICES	0.251143	76.00
76.01	03950	SLEEP LAB	0.193132	76.01
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-3030

Period: From 10/01/2022 To 09/30/2023

Worksheet C Part II

Date/Time Prepared: 2/27/2024 7:17 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	163,530	8,677	154,853	0	0	54.00
60.00	06000	LABORATORY	172,496	2,387	170,109	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	66,658	2,219	64,439	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,822,122	234,446	2,587,676	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,244,976	143,412	2,101,564	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	557,103	9,921	547,182	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	841	9	832	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,378	435	46,943	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,046,390	25,115	1,021,275	0	0	73.00
76.00	03550	PSYCH SERVICES	84,464	553	83,911	0	0	76.00
76.01	03950	SLEEP LAB	208,587	8,604	199,983	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	88,089	415	87,674	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	7,502,634	436,193	7,066,441	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	7,502,634	436,193	7,066,441	0	0	202.00

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

Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part II | Date/Time Prepared: 2/27/2024 7:17 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	163,530	1,067,739	0.153155	54.00
60.00	06000	LABORATORY	172,496	3,824,442	0.045104	60.00
65.00	06500	RESPIRATORY THERAPY	66,658	251,204	0.265354	65.00
66.00	06600	PHYSICAL THERAPY	2,822,122	11,796,802	0.239228	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,244,976	11,997,172	0.187125	67.00
68.00	06800	SPEECH PATHOLOGY	557,103	2,154,180	0.258615	68.00
69.00	06900	ELECTROCARDIOLOGY	841	14,034	0.059926	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,378	145,495	0.325633	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,046,390	10,212,359	0.102463	73.00
76.00	03550	PSYCH SERVICES	84,464	336,318	0.251143	76.00
76.01	03950	SLEEP LAB	208,587	1,080,022	0.193132	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	88,089	0	0.000000	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,546	0.000000	92.00
200.00		Subtotal (sum of lines 50 thru 199)	7,502,634	42,883,313		200.00
201.00		Less Observation Beds	0	0		201.00
202.00		Total (line 200 minus line 201)	7,502,634	42,883,313		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part I Date/Time Prepared: 2/27/2024 7:17 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	418,283	0	418,283	12,055	34.70	30.00
200.00	Total (lines 30 through 199)	418,283		418,283	12,055		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	4,572	158,648	30.00
200.00	Total (lines 30 through 199)	4,572	158,648	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/27/2024 7:17 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,677	1,067,739	0.008127	390,117	3,170	54.00
60.00	06000	LABORATORY	2,387	3,824,442	0.000624	1,532,325	956	60.00
65.00	06500	RESPIRATORY THERAPY	2,219	251,204	0.008833	96,024	848	65.00
66.00	06600	PHYSICAL THERAPY	234,446	11,796,802	0.019874	4,570,952	90,843	66.00
67.00	06700	OCCUPATIONAL THERAPY	143,412	11,997,172	0.011954	4,635,254	55,410	67.00
68.00	06800	SPEECH PATHOLOGY	9,921	2,154,180	0.004605	688,733	3,172	68.00
69.00	06900	ELECTROCARDIOLOGY	9	14,034	0.000641	5,833	4	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	435	145,495	0.002990	24,684	74	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,115	10,212,359	0.002459	3,495,944	8,597	73.00
76.00	03550	PSYCH SERVICES	553	336,318	0.001644	71,145	117	76.00
76.01	03950	SLEEP LAB	8,604	1,080,022	0.007967	593,744	4,730	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	415	0	0.000000	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,546	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	436,193	42,883,313		16,104,755	167,921	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part III Date/Time Prepared: 2/27/2024 7:17 am

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	12,055	0.00	4,572	30.00
200.00		Total (lines 30 through 199)		0	12,055		4,572	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: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/27/2024 7:17 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCH SERVICES	0	0	0	0	0	76.00
76.01	03950	SLEEP LAB	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3030

Period: From 10/01/2022 To 09/30/2023

Worksheet D Part IV
Date/Time Prepared: 2/27/2024 7:17 am

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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,067,739	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	3,824,442	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	251,204	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,796,802	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	11,997,172	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,154,180	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,034	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	145,495	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,212,359	0.000000	73.00
76.00	03550	PSYCH SERVICES	0	0	0	336,318	0.000000	76.00
76.01	03950	SLEEP LAB	0	0	0	1,080,022	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,546	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	42,883,313		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3030

Period: From 10/01/2022 To 09/30/2023

Worksheet D Part IV Date/Time Prepared: 2/27/2024 7:17 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	390,117	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	1,532,325	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	96,024	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	4,570,952	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	4,635,254	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	688,733	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	5,833	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	24,684	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,495,944	0	0	0	73.00
76.00	03550	PSYCH SERVICES	0.000000	71,145	0	0	0	76.00
76.01	03950	SLEEP LAB	0.000000	593,744	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		16,104,755	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/27/2024 7:17 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.153155	0	0	0	0	54.00
60.00	06000	LABORATORY	0.045104	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.265354	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.239228	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.187125	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.258615	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.059926	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.325633	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.102463	0	0	0	0	73.00
76.00	03550	PSYCH SERVICES	0.251143	0	0	0	0	76.00
76.01	03950	SLEEP LAB	0.193132	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/27/2024 7:17 am

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				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03550	PSYCH SERVICES	0	0	76.00
76.01	03950	SLEEP LAB	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part I | Date/Time Prepared: 2/27/2024 7:17 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	418,283	0	418,283	12,055	34.70	30.00
200.00	Total (lines 30 through 199)	418,283		418,283	12,055		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	152	5,274	30.00
200.00	Total (lines 30 through 199)	152	5,274	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/27/2024 7:17 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,677	1,067,739	0.008127	1,781	14	54.00
60.00	06000	LABORATORY	2,387	3,824,442	0.000624	47,169	29	60.00
65.00	06500	RESPIRATORY THERAPY	2,219	251,204	0.008833	682	6	65.00
66.00	06600	PHYSICAL THERAPY	234,446	11,796,802	0.019874	164,399	3,267	66.00
67.00	06700	OCCUPATIONAL THERAPY	143,412	11,997,172	0.011954	165,149	1,974	67.00
68.00	06800	SPEECH PATHOLOGY	9,921	2,154,180	0.004605	26,052	120	68.00
69.00	06900	ELECTROCARDIOLOGY	9	14,034	0.000641	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	435	145,495	0.002990	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,115	10,212,359	0.002459	116,959	288	73.00
76.00	03550	PSYCH SERVICES	553	336,318	0.001644	3,430	6	76.00
76.01	03950	SLEEP LAB	8,604	1,080,022	0.007967	28,881	230	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	415	0	0.000000	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,546	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	436,193	42,883,313		554,502	5,934	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part III Date/Time Prepared: 2/27/2024 7:17 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
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	12,055	0.00	152	30.00
200.00		Total (lines 30 through 199)		0	12,055		152	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: 15-3030

Period: From 10/01/2022 To 09/30/2023

Worksheet D Part IV

Date/Time Prepared: 2/27/2024 7:17 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCH SERVICES	0	0	0	0	0	76.00
76.01	03950	SLEEP LAB	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/27/2024 7:17 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,067,739	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	3,824,442	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	251,204	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,796,802	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	11,997,172	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,154,180	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,034	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	145,495	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,212,359	0.000000	73.00
76.00	03550	PSYCH SERVICES	0	0	0	336,318	0.000000	76.00
76.01	03950	SLEEP LAB	0	0	0	1,080,022	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,546	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	42,883,313		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/27/2024 7:17 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,781	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	47,169	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	682	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	164,399	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	165,149	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	26,052	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	116,959	0	0	0	73.00
76.00	03550	PSYCH SERVICES	0.000000	3,430	0	0	0	76.00
76.01	03950	SLEEP LAB	0.000000	28,881	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		554,502	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/27/2024 7:17 am

	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)	12,055	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,055	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)	12,055	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)	4,572	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)	9,928,688	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)	9,928,688	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)	9,928,688	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)	823.62	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,765,591	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)	3,765,591	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/27/2024 7:17 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	2,792,463	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)	6,558,054	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)	158,648	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	167,921	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	326,569	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	6,231,485	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 Date/Time Prepared: 2/27/2024 7:17 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	418,283	9,928,688	0.042129	0	0	90.00
91.00	Nursing Program cost	0	9,928,688	0.000000	0	0	91.00
92.00	Allied health cost	0	9,928,688	0.000000	0	0	92.00
93.00	All other Medical Education	0	9,928,688	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/27/2024 7:17 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,055	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,055	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)	12,055	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)	152	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)	9,928,688	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)	9,928,688	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)	9,928,688	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)	823.62	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	125,190	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)	125,190	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/27/2024 7:17 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	97,975	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)	223,165	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)	5,274	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	5,934	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	11,208	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	211,957	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-3030	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/27/2024 7:17 am
	Title XIX	Hospital	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	418,283	9,928,688	0.042129	0	0	90.00
91.00	Nursing Program cost	0	9,928,688	0.000000	0	0	91.00
92.00	Allied health cost	0	9,928,688	0.000000	0	0	92.00
93.00	All other Medical Education	0	9,928,688	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/27/2024 7:17 am

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		10,513,802		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.153155	390,117	59,748	54.00
60.00	06000	LABORATORY	0.045104	1,532,325	69,114	60.00
65.00	06500	RESPIRATORY THERAPY	0.265354	96,024	25,480	65.00
66.00	06600	PHYSICAL THERAPY	0.239228	4,570,952	1,093,500	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.187125	4,635,254	867,372	67.00
68.00	06800	SPEECH PATHOLOGY	0.258615	688,733	178,117	68.00
69.00	06900	ELECTROCARDIOLOGY	0.059926	5,833	350	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.325633	24,684	8,038	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.102463	3,495,944	358,205	73.00
76.00	03550	PSYCH SERVICES	0.251143	71,145	17,868	76.00
76.01	03950	SLEEP LAB	0.193132	593,744	114,671	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		16,104,755	2,792,463	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)		16,104,755		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/27/2024 7:17 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		398,924		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.153155	1,781	273	54.00
60.00	06000	LABORATORY	0.045104	47,169	2,128	60.00
65.00	06500	RESPIRATORY THERAPY	0.265354	682	181	65.00
66.00	06600	PHYSICAL THERAPY	0.239228	164,399	39,329	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.187125	165,149	30,904	67.00
68.00	06800	SPEECH PATHOLOGY	0.258615	26,052	6,737	68.00
69.00	06900	ELECTROCARDIOLOGY	0.059926	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.325633	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.102463	116,959	11,984	73.00
76.00	03550	PSYCH SERVICES	0.251143	3,430	861	76.00
76.01	03950	SLEEP LAB	0.193132	28,881	5,578	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		554,502	97,975	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)		554,502		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3030	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/27/2024 7:17 am
	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)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs 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 chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	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)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	0	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		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)	0	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	0	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)	0	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	0	40.00
40.01	Sequestration adjustment (see instructions)	0	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	0	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	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
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3030	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/27/2024 7:17 am
	Title XVIII	Hospital	PPS

		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I Date/Time Prepared: 2/27/2024 7:17 am

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		8,882,800		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		8,882,800		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		105,932		0	6.02
7.00	Total Medicare program liability (see instructions)		8,776,868		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-3030	Period: From 10/01/2022 To 09/30/2023	Worksheet E-1 Part II Date/Time Prepared: 2/27/2024 7:17 am
	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: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-3 Part III Date/Time Prepared: 2/27/2024 7:17 am

		Title XVIII	Hospital	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	8,674,383	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0144	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	426,780	3.00
4.00	Outlier Payments	0	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	33.027397	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	9,101,163	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	9,101,163	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	9,101,163	19.00
20.00	Deductibles	106,584	20.00
21.00	Subtotal (line 19 minus line 20)	8,994,579	21.00
22.00	Coinsurance	43,725	22.00
23.00	Subtotal (line 21 minus line 22)	8,950,854	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	7,899	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	5,134	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	7,068	26.00
27.00	Subtotal (sum of lines 23 and 25)	8,955,988	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.98	Recovery of accelerated depreciation.	0	31.98
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	8,955,988	32.00
32.01	Sequestration adjustment (see instructions)	179,120	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	8,882,800	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-105,932	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)		
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-3 Part VII Date/Time Prepared: 2/27/2024 7:17 am

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	364,068		8.00
9.00	Ancillary service charges	554,502	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	918,570	0	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)	918,570	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	918,570	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G | Date/Time Prepared: 2/27/2024 7:17 am

		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	400	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	4,681,184	0	0	0	4.00
5.00	Other receivable	1,900	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,920,632	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	200,463	0	0	0	8.00
9.00	Other current assets	72,993	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	2,036,308	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	472,545	0	0	0	17.00
18.00	Accumulated depreciation	0	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	1,393,010	0	0	0	23.00
24.00	Accumulated depreciation	-68,231	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)	1,797,324	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	-583,134	0	0	0	33.00
34.00	Other assets	23,040,002	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	22,456,868	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	26,290,500	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	538,055	0	0	0	37.00
38.00	Salaries, wages, and fees payable	757,304	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				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,214,227	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,509,586	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	5,666,505	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	5,666,505	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,176,091	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	18,114,409				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)	18,114,409	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	26,290,500	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-1 | Date/Time Prepared: 2/27/2024 7:17 am

		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		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,357,908				2.00
3.00	Total (sum of line 1 and line 2)		2,357,908		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)		2,357,908		0		11.00
12.00	ROUNDING	5		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)		5		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		2,357,903		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	ROUNDING		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: 15-3030 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/27/2024 7:17 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	27,738,373		27,738,373	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)	27,738,373		27,738,373	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)	27,738,373		27,738,373	17.00
18.00	Ancillary services	41,462,942	0	41,462,942	18.00
19.00	Outpatient services	0	1,416,340	1,416,340	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	OBSERVATION BEDS	3,546	0	3,546	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	69,204,861	1,416,340	70,621,201	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		18,252,581		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)		18,252,581		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-3030	Period: From 10/01/2022 To 09/30/2023	Worksheet G-3 Date/Time Prepared: 2/27/2024 7:17 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	70,621,201	1.00
2.00	Less contractual allowances and discounts on patients' accounts	50,315,481	2.00
3.00	Net patient revenues (line 1 minus line 2)	20,305,720	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	18,252,581	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,053,139	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	49,469	14.00
15.00	Revenue from rental of living quarters	8,525	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	64	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	1,345	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	335	24.00
24.50	COVID-19 PHE Funding	245,031	24.50
25.00	Total other income (sum of lines 6-24)	304,769	25.00
26.00	Total (line 5 plus line 25)	2,357,908	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)	2,357,908	29.00