

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: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/20/2024 10:27 am
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**PART I - COST REPORT STATUS**

Provider use only 1.  Electronically prepared cost report Date: 5/20/2024 Time: 10:27 am  
 2.  Manually prepared cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

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

**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 Community Rehabilitation Hospital South ( 15-3044 ) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2			
1				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				2
3	Signatory Title	CEO			3
4	Date				4

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
		1.00	2.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00	HOSPITAL	0	56,726	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	2.00
3.00	SUBPROVIDER - IRF	0	0	0	0	3.00
5.00	SWING BED - SNF	0	0	0	0	5.00
6.00	SWING BED - NF	0	0	0	0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0	0	7.00
200.00	TOTAL	0	56,726	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 15-3044		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/20/2024 10:27 am					
1.00		2.00		3.00		4.00							
Hospital and Hospital Health Care Complex Address:													
1.00	Street: 607 Greenwood Springs Drive			PO Box:						1.00			
2.00	City: Greenwood			State: IN		Zip Code: 46143		County: Johnson		2.00			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00			
3.00	Hospital and Hospital-Based Component Identification:		Hospital		Community Rehabilitation Hospital South	153044	26900	5	09/18/2018	N	P	O	3.00
4.00	Subprovider - IPF												4.00
5.00	Subprovider - IRF												5.00
6.00	Subprovider - (Other)												6.00
7.00	Swing Beds - SNF												7.00
8.00	Swing Beds - NF												8.00
9.00	Hospital-Based SNF												9.00
10.00	Hospital-Based NF												10.00
11.00	Hospital-Based OLTC												11.00
12.00	Hospital-Based HHA												12.00
13.00	Separately Certified ASC												13.00
14.00	Hospital-Based Hospice												14.00
15.00	Hospital-Based Health Clinic - RHC												15.00
16.00	Hospital-Based Health Clinic - FOHC												16.00
17.00	Hospital-Based (CMHC) I												17.00
18.00	Renal Dialysis												18.00
19.00	Other												19.00
							From:	To:					
							1.00	2.00					
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2023	12/31/2023		20.00			
21.00	Type of Control (see instructions)						5			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				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-3044			Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/20/2024 10:27 am		
		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.	96	161	0	0	1,369			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	XVII	XIX	
						1.00	2.00	3.00	
<b>Prospective Payment System (PPS)-Capital</b>									
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
<b>Teaching Hospitals</b>									
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.								58.00

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	V	XVIII	XIX	
	1.00	2.00	3.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.			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
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	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	
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62.00	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
63.00	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

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

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				1.00	
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?				68.00
				1.00	2.00 3.00
<b>Inpatient Psychiatric Facility PPS</b>					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0 71.00
<b>Inpatient Rehabilitation Facility PPS</b>					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N N	0 76.00
				1.00	
<b>Long Term Care Hospital PPS</b>					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
<b>TEFRA Providers</b>					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
			1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions)		N		0 88.00
		Column 2: Enter the number of approved permanent adjustments.			
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge
			1.00	2.00	3.00
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.		0.00		0 89.00
			V	XIX	
			1.00	2.00	
<b>Title V and XIX Services</b>					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y 90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N 91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N 92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N 93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N 94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00 95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N 96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00 97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/20/2024 10:27 am	
		V 1.00	XIX 2.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. 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	
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00
				1.00	2.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.		N		111.00
				1.00	2.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
<b>Miscellaneous Cost Reporting Information</b>					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/20/2024 10:27 am
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	124,903	0	0
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N	118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N	121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.		N	123.00
<b>Certified Transplant Center Information</b>				
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N	125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
<b>All Providers</b>				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	HBO616
		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: LIFEPOINT HEALTHCARE	Contractor's Name: PALMETTOA		Contractor's Number: 10001
142.00	Street: 330 SEVEN SPRINGS WAY	PO Box:		
143.00	City: BRENTWOOD	State: TN	Zip Code: 37027	
			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: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/20/2024 10:27 am
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				1.00	
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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
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Multi campus						
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
166.01							0.00	166.01
166.02							0.00	166.02
166.03							0.00	166.03

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

					Beginning	Ending	
					1.00	2.00	

170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						170.00
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							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
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HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-3044		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part II Date/Time Prepared: 5/20/2024 10:27 am	
				Y/N	Date		
				1.00	2.00		
<b>PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE</b>							
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
				Y/N	Date		V/I
				1.00	2.00		3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
				Y/N	Type		Date
				1.00	2.00		3.00
<b>Financial Data and Reports</b>							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/31/2024			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
				Y/N	Legal Oper.		
				1.00	2.00		
<b>Approved Educational Activities</b>							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
<b>Bad Debts</b>							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N			14.00
<b>Bed Complement</b>							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
<b>PS&amp;R Data</b>							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	02/29/2024	Y	02/29/2024		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



		3.00	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER	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: 15-3044

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/20/2024 10:27 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P		
	Line No.				Visits / Trips	Title V	
	1.00	2.00	3.00	4.00	5.00		
<b>PART I - STATISTICAL DATA</b>							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	44	16,060	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)		44	16,060	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		44	16,060	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	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)		44				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: 15-3044

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/20/2024 10:27 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
<b>PART I - STATISTICAL DATA</b>						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,112	257	12,576		1.00
2.00	HMO and other (see instructions)	2,341	1,369			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0	0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,112	257	12,576		7.00
8.00	INTENSIVE CARE UNIT	0	0	0		8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY					13.00
14.00	Total (see instructions)	5,112	257	12,576	0.00	95.40
15.00	CAH visits	0	0	0		15.00
15.10	REH hours and visits	0	0	0		15.10
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	95.40
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: 15-3044

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/20/2024 10:27 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
<b>PART I - STATISTICAL DATA</b>							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	468	20	1,108	1.00
2.00	HMO and other (see instructions)			192	116		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	468	20	1,108	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	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 15-3044		Period: From 01/01/2023 To 12/31/2023		Worksheet S-3 Part II Date/Time Prepared: 5/20/2024 10:27 am	
	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
<b>PART II - WAGE DATA</b>								
<b>SALARIES</b>								
1.00	Total salaries (see instructions)	200.00	8,305,112	0	8,305,112	198,752.00	41.79	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	527,227	527,227	14,916.00	35.35	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract Labor: Direct Patient Care		2,985,624	0	2,985,624	35,741.00	83.53	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		123,626	0	123,626	688.00	179.69	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		823,838	0	823,838	13,009.00	63.33	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
<b>WAGE-RELATED COSTS</b>								
17.00	Wage-related costs (core) (see instructions)		1,131,132	0	1,131,132			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		76,674	0	76,674			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52



HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-3044

Period:  
From 01/01/2023  
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Worksheet S-3  
Part II  
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5/20/2024 10:27 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)	0	0	0			25.53
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	1,498,522	0	1,498,522	26,072.00	57.48	27.00
28.00	Administrative & General under contract (see inst.)	1,588	0	1,588	151.00	10.52	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	55,914	0	55,914	2,297.00	24.34	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	181,234	0	181,234	9,041.00	20.05	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	476,391	0	476,391	20,619.00	23.10	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	149,050	0	149,050	3,898.00	38.24	38.00
39.00	Central Services and Supply	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	220,794	0	220,794	4,811.00	45.89	40.00
41.00	Medical Records & Medical Records Library	260,373	0	260,373	7,767.00	33.52	41.00
42.00	Social Service	527,227	-527,227	0	0.00	0.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-3044

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/20/2024 10:27 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	8,306,700	0	8,306,700	198,903.00	41.76	1.00
2.00	Excluded area salaries (see instructions)	0	527,227	527,227	14,916.00	35.35	2.00
3.00	Subtotal salaries (line 1 minus line 2)	8,306,700	-527,227	7,779,473	183,987.00	42.28	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,933,088	0	3,933,088	49,438.00	79.56	4.00
5.00	Subtotal wage-related costs (see inst.)	1,131,132	0	1,131,132	0.00	14.54	5.00
6.00	Total (sum of lines 3 thru 5)	13,370,920	-527,227	12,843,693	233,425.00	55.02	6.00
7.00	Total overhead cost (see instructions)	3,371,093	-527,227	2,843,866	74,656.00	38.09	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/20/2024 10:27 am
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		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	45,683	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	394,701	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	-66	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	33,456	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	65,109	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	566,538	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	22,280	20.00
<b>OTHER</b>			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	3,430	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,131,131	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part V Date/Time Prepared: 5/20/2024 10:27 am
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost	2,985,624	1,131,132	1.00
2.00	Hospital	2,985,624	1,131,132	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY	0	0	8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/20/2024 10:27 am
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				1.00		
<b>PART I - HOSPITAL AND HOSPITAL COMPLEX DATA</b>						
<b>Uncompensated and Indigent Care Cost-to-Charge Ratio</b>						
1.00	Cost to charge ratio (see instructions)			0.381414	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			0	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00	
6.00	Medicaid charges			0	6.00	
7.00	Medicaid cost (line 1 times line 6)			0	7.00	
8.00	Difference between net revenue and costs for Medicaid program (see instructions)			0	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone CHIP			0	9.00	
10.00	Stand-alone CHIP charges			0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)			0	12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)			0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			0	19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
Uncompensated care cost (see instructions for each line)						
20.00	Charity care charges and uninsured discounts (see instructions)	0	0	0	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	0	0	0	21.00	
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00	
23.00	Cost of charity care (see instructions)	0	0	0	23.00	
				1.00		
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00	
25.01	Charges for insured patients' liability (see instructions)			0	25.01	
26.00	Bad debt amount (see instructions)			0	26.00	
27.00	Medicare reimbursable bad debts (see instructions)			23,273	27.00	
27.01	Medicare allowable bad debts (see instructions)			35,805	27.01	
28.00	Non-Medicare bad debt amount (see instructions)			-35,805	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			-1,125	29.00	
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			-1,125	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			-1,125	31.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/20/2024 10:27 am
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			1.00		
<b>PART II - HOSPITAL DATA</b>					
<b>Uncompensated and Indigent Care Cost-to-Charge Ratio</b>					
1.00	Cost to charge ratio (see instructions)		0.000000	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			5.00	
6.00	Medicaid charges			6.00	
7.00	Medicaid cost (line 1 times line 6)			7.00	
8.00	Difference between net revenue and costs for Medicaid program (see instructions)			8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			9.00	
10.00	Stand-alone CHIP charges			10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)			11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)			12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)			16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			19.00	
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
Uncompensated care cost (see instructions for each line)					
20.00	Charity care charges and uninsured discounts (see instructions)	0	0	0	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	0	0	0	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	0	0	0	23.00
			1.00		
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
25.01	Charges for insured patients' liability (see instructions)			0	25.01
26.00	Bad debt amount (see instructions)			0	26.00
27.00	Medicare reimbursable bad debts (see instructions)			0	27.00
27.01	Medicare allowable bad debts (see instructions)			0	27.01
28.00	Non-Medicare bad debt amount (see instructions)			0	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			0	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			0	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			0	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-3044

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

Worksheet A  
Date/Time Prepared:  
5/20/2024 10:27 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		1,771,256	1,771,256	51,590	1,822,846	1.00
2.00	00200		279,283	279,283	130,558	409,841	2.00
3.00	00300		182,148	182,148	-182,148	0	3.00
4.00	00400	0	1,343,578	1,343,578	29	1,343,607	4.00
5.00	00500	1,498,522	2,808,466	4,306,988	0	4,306,988	5.00
7.00	00700	55,914	486,854	542,768	0	542,768	7.00
8.00	00800	0	95,314	95,314	0	95,314	8.00
9.00	00900	181,234	38,815	220,049	0	220,049	9.00
10.00	01000	476,391	246,541	722,932	0	722,932	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	149,050	88,342	237,392	-754	236,638	13.00
14.00	01400	0	23,701	23,701	0	23,701	14.00
15.00	01500	220,794	75,706	296,500	0	296,500	15.00
16.00	01600	260,373	1,802	262,175	0	262,175	16.00
17.00	01700	527,227	8,324	535,551	-535,551	0	17.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,923,258	3,231,113	6,154,371	83,487	6,237,858	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	0	0	50.00
54.00	05400	0	81,727	81,727	-81,727	0	54.00
60.00	06000	0	2,905	2,905	0	2,905	60.00
65.00	06500	79,345	5,516	84,861	0	84,861	65.00
66.00	06600	851,577	57,957	909,534	0	909,534	66.00
67.00	06700	715,706	4,824	720,530	0	720,530	67.00
68.00	06800	365,721	0	365,721	0	365,721	68.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	240,890	240,890	165	241,055	73.00
74.00	07400	0	1,200	1,200	-1,200	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	60,149	60,149	0	60,149	95.00
98.00	09850	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		8,305,112	11,136,411	19,441,523	-535,551	18,905,972	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	535,551	535,551	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
194.12	07960	0	0	0	0	0	194.12
200.00		8,305,112	11,136,411	19,441,523	0	19,441,523	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-3044

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

Worksheet A  
Date/Time Prepared:  
5/20/2024 10:27 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-14,082	1,808,764	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-18,402	391,439	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-416,903	926,704	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	747,088	5,054,076	5.00
7.00	00700	OPERATION OF PLANT	-1,157	541,611	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	95,314	8.00
9.00	00900	HOUSEKEEPING	0	220,049	9.00
10.00	01000	DIETARY	-25,818	697,114	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	236,638	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	23,701	14.00
15.00	01500	PHARMACY	0	296,500	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-55	262,120	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	113,792	6,351,650	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	2,905	60.00
65.00	06500	RESPIRATORY THERAPY	0	84,861	65.00
66.00	06600	PHYSICAL THERAPY	0	909,534	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	720,530	67.00
68.00	06800	SPEECH PATHOLOGY	0	365,721	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	241,055	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	-60,149	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	324,314	19,230,286	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	535,551	194.00
194.01	07951	IDLE SPACE	0	0	194.01
194.02	07952	DISTRICT	0	0	194.02
194.03	07953	DISTRICT SALES	0	0	194.03
194.04	07954	CENTRALIZED ADMINISTRATIONS (CAD)	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	194.07
194.08	07959	LACUNA HEALTH	0	0	194.08
194.09	07958	SALES & MARKETING	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	194.12
200.00		TOTAL (SUM OF LINES 118 through 199)	324,314	19,765,837	200.00



RECLASSIFICATIONS

Provider CCN: 15-3044

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

Worksheet A-6

Date/Time Prepared:  
5/20/2024 10:27 am

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
<b>A - RECLASS NON ALLOWABLE CASE MANAGER</b>						
1.00	NONALLOWABLE CASE MANAGER		194.00	527,227	8,324	1.00
	TOTALS			527,227	8,324	
<b>B - RECLASS RELATED PARTY</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	29	1.00
2.00	ADULTS & PEDIATRICS		30.00	0	560	2.00
3.00	DRUGS CHARGED TO PATIENTS		73.00	0	165	3.00
	TOTALS			0	754	
<b>C - RECLASS RENAL DIALYSIS</b>						
1.00	ADULTS & PEDIATRICS		30.00	0	1,200	1.00
	TOTALS			0	1,200	
<b>D - RECLASS RADIOLOGY</b>						
1.00	ADULTS & PEDIATRICS		30.00	0	81,727	1.00
	TOTALS			0	81,727	
500.00	Grand Total: Increases			527,227	92,005	500.00

RECLASSIFICATIONS

Provider CCN: 15-3044

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

Worksheet A-6  
Date/Time Prepared:  
5/20/2024 10:27 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - RECLASS NON ALLOWABLE CASE MANAGER							
1.00	SOCIAL SERVICE	17.00	527,227	8,324	0		1.00
	TOTALS		527,227	8,324			
B - RECLASS RELATED PARTY							
1.00	NURSING ADMINISTRATION	13.00	0	754	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	754			
C - RECLASS RENAL DIALYSIS							
1.00	RENAL DIALYSIS	74.00	0	1,200	0		1.00
	TOTALS		0	1,200			
D - RECLASS RADIOLOGY							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	81,727	0		1.00
	TOTALS		0	81,727			
500.00	Grand Total: Decreases		527,227	92,005			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-3044

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/20/2024 10:27 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	558,498	307,557	0	307,557	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	2,042,131	149,561	0	149,561	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	2,600,629	457,118	0	457,118	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	2,600,629	457,118	0	457,118	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	866,055	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	2,191,692	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	3,057,747	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	3,057,747	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-3044

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/20/2024 10:27 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	69,261	1,701,995	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	232,697	46,586	0	0	0	2.00
3.00	Total (sum of lines 1-2)	301,958	1,748,581	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,771,256				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	279,283				2.00
3.00	Total (sum of lines 1-2)	0	2,050,539				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-3044

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/20/2024 10:27 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	866,055	0	866,055	0.283233	6,791	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,191,692	0	2,191,692	0.716767	17,186	2.00
3.00	Total (sum of lines 1-2)	3,057,747	0	3,057,747	1.000000	23,977	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	44,799	0	51,590	61,173	1,701,995	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	113,372	0	130,558	214,295	46,586	2.00
3.00	Total (sum of lines 1-2)	158,171	0	182,148	275,468	1,748,581	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	0	797	44,799	0	1,808,764	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	17,186	113,372	0	391,439	2.00
3.00	Total (sum of lines 1-2)	0	17,983	158,171	0	2,200,203	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-3044

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

Worksheet A-8

Date/Time Prepared:  
5/20/2024 10:27 am

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
				Cost Center		Line #	
				1.00	2.00	3.00	
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)	B	-44,631		ADMINISTRATIVE & GENERAL	5.00	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	-8,189		ADMINISTRATIVE & GENERAL	5.00	0 7.00
8.00	Television and radio service (chapter 21)	A	-1,157		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	-334				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	816,646				0 12.00
13.00	Laundry and linen service		0			0.00	0 13.00
14.00	Cafeteria-employees and guests	B	-25,818		DIETARY	10.00	0 14.00
15.00	Rental of quarters to employee and others		0			0.00	0 15.00
16.00	Sale of medical and surgical supplies to other than patients		0			0.00	0 16.00
17.00	Sale of drugs to other than patients		0			0.00	0 17.00
18.00	Sale of medical records and abstracts	B	-55		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		0			0.00	0 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0		RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0		PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0		*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0 26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0 27.00
28.00	Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant			0		0.00	0 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0		OCCUPATIONAL THERAPY	67.00	30.00
30.99	Hospice (non-distinct) (see instructions)				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

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-3044

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

Worksheet A-8

Date/Time Prepared:  
5/20/2024 10:27 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		3.00
33.00 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.00
33.01 MISCELLANEOUS INCOME	B	-6,210	ADMINISTRATIVE & GENERAL		5.00	0 33.01
33.02 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.02
33.03 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.03
33.04 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.04
33.05 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.05
33.06 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.06
33.07 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.07
33.08 MEDICARE BAD DEBT - PART A	A	-35,805	ADMINISTRATIVE & GENERAL		5.00	0 33.08
33.09 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.09
33.10 OTHER MEDICARE NON ALLOWABLE	A	-5,302	ADMINISTRATIVE & GENERAL		5.00	0 33.10
33.11 OTHER OPERATING - PATIENT RELATIONS	A	-10,314	ADMINISTRATIVE & GENERAL		5.00	0 33.11
33.12 OTHER OPERATING - PUBLIC RELATIONS	A	-99	ADMINISTRATIVE & GENERAL		5.00	0 33.12
33.13 OTHER OPERATING - MARKETING	A	-2,467	ADMINISTRATIVE & GENERAL		5.00	0 33.13
33.14 OTHER OPERATING - INTEREST	A	-559	ADMINISTRATIVE & GENERAL		5.00	0 33.14
33.15 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.15
33.16 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.16
33.17 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.17
33.18 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.18
33.19 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.19
33.20 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.20
33.21 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.21
33.22 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.22
33.23 CHARITABLE CONTRIBUTIONS	A	-3,667	ADMINISTRATIVE & GENERAL		5.00	0 33.23
33.24 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.24
33.25 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.25
33.26 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.26
33.27 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.27
33.28 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.28
33.29 CABLE TV AND SATELLITE	A	-17,693	ADMINISTRATIVE & GENERAL		5.00	0 33.29
33.30 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.30
33.31 MARKETING BONUS	A	-85,360	ADMINISTRATIVE & GENERAL		5.00	0 33.31
33.32 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.32
33.33 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.33
33.34 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.34
33.35 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.35
33.36 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.36
33.37 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.37
33.38 OTHER ADJUSTMENTS (SPECI FY) (3)		0			0.00	0 33.38

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-3044

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

Worksheet A-8

Date/Time Prepared:  
5/20/2024 10:27 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
33.39 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.39
33.40 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.40
33.41 NON ALLOW AMBULANCE COSTS	A	-60,149	AMBULANCE SERVICES		95.00	0	33.41
33.42 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.42
33.43 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.43
33.44 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.44
33.45 BUSINESS INTERRUPTIONS INS PREMIUM	A	-5,994	CAP REL COSTS-BLDG & FIXT		1.00	12	33.45
34.00 MEDI CARE VS BOOK BLDG	A	-8,088	CAP REL COSTS-BLDG & FIXT		1.00	9	34.00
34.01 MEDI CARE VS BOOK MOV EQUIP	A	-14,932	CAP REL COSTS-MVBLE EQUIP		2.00	9	34.01
34.02 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.02
34.03 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.03
34.04 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.04
34.05 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.05
34.06 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.06
34.07 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.07
34.08 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.08
34.09 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.09
34.10 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.10
34.11 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.11
34.12 NON ALLOWABLE LOBBYING FEES	A	-144	ADMINISTRATIVE & GENERAL		5.00	0	34.12
34.13 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.13
34.14 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.14
34.15 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.15
34.16 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.16
34.17 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.17
34.18 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.18
34.19 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.19
34.20 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.20
34.21 PATIENT PHONE - DEPREC EQUIP	A	-3,470	CAP REL COSTS-MVBLE EQUIP		2.00	9	34.21
34.22 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.22
34.23 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.23
34.24 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.24
34.25 DEFERRED PRE OPENING COSTS	A	265,008	ADMINISTRATIVE & GENERAL		5.00	0	34.25
34.26 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.26
34.27 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.27
34.28 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.28
34.40 NONALLOWABLE VEBA EXPENSE	A	-421,456	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	34.40
34.41 ALLOWABLE VEBA CLAIMS	A	4,553	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	34.41
35.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	35.00
35.01 PHYSICIAN FEE ADJUSTMENT	A	-114,126	ADMINISTRATIVE & GENERAL		5.00	0	35.01



Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		3.00
35.02 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.02
35.03 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.03
35.04 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.04
35.05 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.05
35.06 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.06
35.07 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.07
35.08 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.08
35.09 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.09
35.10 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.10
35.11 PHYSICIAN FEE ADJUSTMENT	A	114,126	ADULTS & PEDIATRICS		30.00	0 35.11
35.12 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.12
35.13 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.13
35.14 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.14
35.15 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.15
35.16 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.16
35.17 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.17
35.18 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.18
35.19 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.19
35.20 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.20
35.21 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.21
35.22 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.22
35.23 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.23
35.24 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.24
35.25 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.25
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		324,314				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: 15-3044  
 Period: From 01/01/2023 To 12/31/2023  
 Worksheet A-8-1  
 Date/Time Prepared: 5/20/2024 10:27 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	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR HOME OFFICE COSTS:</b>					
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Costs - Actual	2,140,409	1,323,763
2.00	0.00			0	0
3.00	0.00			0	0
4.00	0.00			0	0
4.09	5.00	ADMINISTRATIVE & GENERAL	Hospital Related services	324,992	324,992
4.17	15.00	PHARMACY	Hospital Related services	42,900	42,900
4.20	30.00	ADULTS & PEDIATRICS	Hospital Related services	51,393	51,393
4.26	54.00	RADIOLOGY-DIAGNOSTIC	Hospital Related services	74,532	74,532
4.33	0.00			0	0
5.00	0			2,634,226	1,817,580

\* 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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>				

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

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

6.00	B	49.00	Lifepoint Health	100.00	6.00
7.00		0.00		0.00	7.00
8.00		0.00		0.00	8.00
9.00	B	51.00	Community Health Network	100.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Date/Time Prepared: 5/20/2024 10:27 am
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	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	816,646	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.09	0	0		4.09
4.17	0	0		4.17
4.20	0	0		4.20
4.26	0	0		4.26
4.33	0	0		4.33
5.00	816,646			5.00

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

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

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

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

6.00	Home Office Cost		6.00
7.00			7.00
8.00			8.00
9.00	Hospital Services		9.00
10.00			10.00
100.00			100.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-3044

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

Worksheet A-8-2

Date/Time Prepared:  
5/20/2024 10:27 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	0.00		0	0	0	0	0	1.00
2.00	30.00	DR. B	1,046	0	1,046	211,500	7	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			1,046	0	1,046		7	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	0.00		0	0	0	0	0	1.00
2.00	30.00	DR. B	712	36	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			712	36	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	0.00		0	0	0	0		1.00
2.00	30.00	DR. B	0	712	334	334		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	712	334	334		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3044

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/20/2024 10:27 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,808,764	1,808,764			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	391,439		391,439		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	926,704	46,633	10,092	983,429	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,054,076	49,841	10,786	177,443	5.00
7.00 00700	OPERATION OF PLANT	541,611	145,377	31,461	6,621	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	95,314	0	0	0	8.00
9.00 00900	HOUSEKEEPING	220,049	21,048	4,555	21,460	9.00
10.00 01000	DIETARY	697,114	142,404	30,818	56,410	10.00
11.00 01100	CAFETERIA	0	148,585	32,156	0	11.00
13.00 01300	NURSING ADMINISTRATION	236,638	11,971	2,591	17,649	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	23,701	94,597	20,472	0	14.00
15.00 01500	PHARMACY	296,500	32,315	6,993	26,145	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	262,120	10,719	2,320	30,831	16.00
17.00 01700	SOCIAL SERVICE	0	14,084	3,048	0	17.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	6,351,650	600,053	129,858	346,154	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	2,905	6,338	1,372	0	60.00
65.00 06500	RESPIRATORY THERAPY	84,861	10,719	2,320	9,395	65.00
66.00 06600	PHYSICAL THERAPY	909,534	352,254	76,232	100,837	66.00
67.00 06700	OCCUPATIONAL THERAPY	720,530	93,893	20,320	84,748	67.00
68.00 06800	SPEECH PATHOLOGY	365,721	27,933	6,045	43,306	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	241,055	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	19,230,286	1,808,764	391,439	920,999	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CASE MANAGER	535,551	0	0	62,430	194.00
194.01 07951	IDLE SPACE	0	0	0	0	194.01
194.02 07952	DISTRICT	0	0	0	0	194.02
194.03 07953	DISTRICT SALES	0	0	0	0	194.03
194.04 07954	CENTRALIZED ADMINISTRATIONS (CAD)	0	0	0	0	194.04
194.05 07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	194.05
194.06 07956	CENTRALIZED STAFFING	0	0	0	0	194.06
194.07 07957	HR MANAGED CARE	0	0	0	0	194.07
194.08 07959	LACUNA HEALTH	0	0	0	0	194.08
194.09 07958	SALES & MARKETING	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
194.12 07960	VISITOR MEALS	0	0	0	0	194.12
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	TOTAL (sum lines 118 through 201)	19,765,837	1,808,764	391,439	983,429	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3044

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/20/2024 10:27 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,292,146				5.00
7.00	00700	OPERATION OF PLANT	265,114	990,184			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34,851		130,165		8.00
9.00	00900	HOUSEKEEPING	97,667	13,301	0	378,080	9.00
10.00	01000	DIETARY	338,854	89,990	0	34,828	1,390,418
11.00	01100	CAFETERIA	66,086	93,896	0	36,340	249,364
13.00	01300	NURSING ADMINISTRATION	98,302	7,565	0	2,928	0
14.00	01400	CENTRAL SERVICES & SUPPLY	50,740	59,779	0	23,136	0
15.00	01500	PHARMACY	132,344	20,421	0	7,903	0
16.00	01600	MEDICAL RECORDS & LIBRARY	111,882	6,774	0	2,622	0
17.00	01700	SOCIAL SERVICE	6,264	8,900	0	3,445	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	2,715,862	379,192	130,165	146,757	1,141,054
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00	06000	LABORATORY	3,881	4,005	0	1,550	0
65.00	06500	RESPIRATORY THERAPY	39,231	6,774	0	2,622	0
66.00	06600	PHYSICAL THERAPY	526,102	222,601	0	86,153	0
67.00	06700	OCCUPATIONAL THERAPY	336,202	59,334	0	22,964	0
68.00	06800	SPEECH PATHOLOGY	161,980	17,652	0	6,832	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	88,139	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,073,501	990,184	130,165	378,080	1,390,418
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NONALLOWABLE CASE MANAGER	218,645	0	0	0	0
194.01	07951	IDLE SPACE	0	0	0	0	0
194.02	07952	DISTRICT	0	0	0	0	0
194.03	07953	DISTRICT SALES	0	0	0	0	0
194.04	07954	CENTRALIZED ADMINISTRATIONS (CAD)	0	0	0	0	0
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	0
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0
194.07	07957	HR MANAGED CARE	0	0	0	0	0
194.08	07959	LACUNA HEALTH	0	0	0	0	0
194.09	07958	SALES & MARKETING	0	0	0	0	0
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0
194.12	07960	VISITOR MEALS	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	5,292,146	990,184	130,165	378,080	1,390,418

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-3044		Period: From 01/01/2023 To 12/31/2023		Worksheet B Part I Date/Time Prepared: 5/20/2024 10:27 am	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	626,427					11.00
13.00	01300	NURSING ADMINISTRATION	18,424	396,068				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	272,425			14.00
15.00	01500	PHARMACY	18,424	0	162,944	703,989		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,849	0	3,630	0	467,747	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	340,850	396,068	11,469	0	231,054	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	14,893	60.00
65.00	06500	RESPIRATORY THERAPY	9,212	0	0	0	2,851	65.00
66.00	06600	PHYSICAL THERAPY	92,122	0	94,382	0	73,681	66.00
67.00	06700	OCCUPATIONAL THERAPY	73,697	0	0	0	74,473	67.00
68.00	06800	SPEECH PATHOLOGY	36,849	0	0	0	47,824	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	703,989	22,971	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	626,427	396,068	272,425	703,989	467,747	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	DISTRICT	0	0	0	0	0	194.02
194.03	07953	DISTRICT SALES	0	0	0	0	0	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	LACUNA HEALTH	0	0	0	0	0	194.08
194.09	07958	SALES & MARKETING	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	0	194.12
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)	626,427	396,068	272,425	703,989	467,747	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3044

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

Worksheet B  
Part I  
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Cost Center Description		SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	23.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500						15.00
16.00	01600						16.00
17.00	01700	35,741					17.00
23.00	02300		0				23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	35,741	0	12,955,927	0	12,955,927	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	0	0	50.00
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	34,944	0	34,944	60.00
65.00	06500	0	0	167,985	0	167,985	65.00
66.00	06600	0	0	2,533,898	0	2,533,898	66.00
67.00	06700	0	0	1,486,161	0	1,486,161	67.00
68.00	06800	0	0	714,142	0	714,142	68.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	1,056,154	0	1,056,154	73.00
74.00	07400	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		35,741	0	18,949,211	0	18,949,211	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	816,626	0	816,626	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
194.12	07960	0	0	0	0	0	194.12
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		35,741	0	19,765,837	0	19,765,837	202.00



ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3044

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/20/2024 10:27 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	46,633	10,092	56,725	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	416,614	49,841	10,786	477,241	5.00
7.00 00700	OPERATION OF PLANT	0	145,377	31,461	176,838	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	21,048	4,555	25,603	9.00
10.00 01000	DIETARY	0	142,404	30,818	173,222	10.00
11.00 01100	CAFETERIA	0	148,585	32,156	180,741	11.00
13.00 01300	NURSING ADMINISTRATION	0	11,971	2,591	14,562	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	94,597	20,472	115,069	14.00
15.00 01500	PHARMACY	0	32,315	6,993	39,308	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	10,719	2,320	13,039	16.00
17.00 01700	SOCIAL SERVICE	0	14,084	3,048	17,132	17.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	600,053	129,858	729,911	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	6,338	1,372	7,710	60.00
65.00 06500	RESPIRATORY THERAPY	0	10,719	2,320	13,039	65.00
66.00 06600	PHYSICAL THERAPY	0	352,254	76,232	428,486	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	93,893	20,320	114,213	67.00
68.00 06800	SPEECH PATHOLOGY	0	27,933	6,045	33,978	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	416,614	1,808,764	391,439	2,616,817	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CASE MANAGER	0	0	0	3,601	194.00
194.01 07951	IDLE SPACE	0	0	0	0	194.01
194.02 07952	DISTRICT	0	0	0	0	194.02
194.03 07953	DISTRICT SALES	0	0	0	0	194.03
194.04 07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	194.04
194.05 07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	194.05
194.06 07956	CENTRALIZED STAFFING	0	0	0	0	194.06
194.07 07957	HR MANAGED CARE	0	0	0	0	194.07
194.08 07959	LACUNA HEALTH	0	0	0	0	194.08
194.09 07958	SALES & MARKETING	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
194.12 07960	VISITOR MEALS	0	0	0	0	194.12
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	416,614	1,808,764	391,439	2,616,817	56,725 202.00

ALLOCATION OF CAPITAL RELATED COSTS				Provider CCN: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/20/2024 10:27 am		
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	487,476					5.00
7.00	00700	OPERATION OF PLANT	24,420	201,640				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,210	0	3,210			8.00
9.00	00900	HOUSEKEEPING	8,996	2,709	0	38,546		9.00
10.00	01000	DIETARY	31,213	18,325	0	3,551	229,565	10.00
11.00	01100	CAFETERIA	6,087	19,121	0	3,705	41,171	11.00
13.00	01300	NURSING ADMINISTRATION	9,055	1,541	0	299	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,674	12,173	0	2,359	0	14.00
15.00	01500	PHARMACY	12,191	4,158	0	806	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,306	1,379	0	267	0	16.00
17.00	01700	SOCIAL SERVICE	577	1,812	0	351	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	250,167	77,219	3,210	14,962	188,394	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	358	816	0	158	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,614	1,379	0	267	0	65.00
66.00	06600	PHYSICAL THERAPY	48,461	45,330	0	8,783	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,968	12,083	0	2,341	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,920	3,595	0	697	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,119	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	467,336	201,640	3,210	38,546	229,565	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	20,140	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	DISTRICT	0	0	0	0	0	194.02
194.03	07953	DISTRICT SALES	0	0	0	0	0	194.03
194.04	07954	CENTRALIZED ADMINISTRATIONS (CAD)	0	0	0	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	LACUNA HEALTH	0	0	0	0	0	194.08
194.09	07958	SALES & MARKETING	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	0	194.12
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)	487,476	201,640	3,210	38,546	229,565	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-3044		Period: From 01/01/2023 To 12/31/2023		Worksheet B Part II Date/Time Prepared: 5/20/2024 10:27 am	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	250,825					11.00
13.00	01300	NURSING ADMINISTRATION	7,377	33,852				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	134,275			14.00
15.00	01500	PHARMACY	7,377	0	80,313	145,661		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,754	0	1,789	0	43,312	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	136,479	33,852	5,653	0	21,390	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	1,379	60.00
65.00	06500	RESPIRATORY THERAPY	3,689	0	0	0	264	65.00
66.00	06600	PHYSICAL THERAPY	36,886	0	46,520	0	6,824	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,509	0	0	0	6,898	67.00
68.00	06800	SPEECH PATHOLOGY	14,754	0	0	0	4,429	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	145,661	2,128	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	250,825	33,852	134,275	145,661	43,312	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	DISTRICT	0	0	0	0	0	194.02
194.03	07953	DISTRICT SALES	0	0	0	0	0	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0	194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	0	194.05
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	LACUNA HEALTH	0	0	0	0	0	194.08
194.09	07958	SALES & MARKETING	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	0	194.12
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)	250,825	33,852	134,275	145,661	43,312	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/20/2024 10:27 am		
Cost Center	Description	SOCIAL SERVICE	PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	23.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
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	19,872				17.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0			23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	19,872		1,501,076	0	1,501,076
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0		0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		0	0	0
60.00	06000	LABORATORY	0		10,421	0	10,421
65.00	06500	RESPIRATORY THERAPY	0		22,794	0	22,794
66.00	06600	PHYSICAL THERAPY	0		627,106	0	627,106
67.00	06700	OCCUPATIONAL THERAPY	0		200,900	0	200,900
68.00	06800	SPEECH PATHOLOGY	0		74,871	0	74,871
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0		155,908	0	155,908
74.00	07400	RENAL DIALYSIS	0		0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0		0	0	0
91.00	09100	EMERGENCY	0		0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0		0	0	0
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,872	0	2,593,076	0	2,593,076
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		0	0	0
194.00	07950	NONALLOWABLE CASE MANAGER	0		23,741	0	23,741
194.01	07951	IDLE SPACE	0		0	0	0
194.02	07952	DISTRICT	0		0	0	0
194.03	07953	DISTRICT SALES	0		0	0	0
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0		0	0	0
194.05	07955	CENTRALIZED BUSINESS (CBO)	0		0	0	0
194.06	07956	CENTRALIZED STAFFING	0		0	0	0
194.07	07957	HR MANAGED CARE	0		0	0	0
194.08	07959	LACUNA HEALTH	0		0	0	0
194.09	07958	SALES & MARKETING	0		0	0	0
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0		0	0	0
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0		0	0	0
194.12	07960	VISITOR MEALS	0		0	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	19,872	0	2,616,817	0	2,616,817

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-3044

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

Worksheet B-1

Date/Time Prepared:  
5/20/2024 10:27 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET #1)	MVBLE EQUIP (SQUARE FEET #2)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	23,117				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		23,117			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	596	596	8,305,112		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	637	637	1,498,522	-5,292,146	14,473,691
7.00 00700	OPERATION OF PLANT	1,858	1,858	55,914	0	725,070
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	95,314
9.00 00900	HOUSEKEEPING	269	269	181,234	0	267,112
10.00 01000	DIETARY	1,820	1,820	476,391	0	926,746
11.00 01100	CAFETERIA	1,899	1,899	0	0	180,741
13.00 01300	NURSING ADMINISTRATION	153	153	149,050	0	268,849
14.00 01400	CENTRAL SERVICES & SUPPLY	1,209	1,209	0	0	138,770
15.00 01500	PHARMACY	413	413	220,794	0	361,953
16.00 01600	MEDICAL RECORDS & LIBRARY	137	137	260,373	0	305,990
17.00 01700	SOCIAL SERVICE	180	180	0	0	17,132
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	7,669	7,669	2,923,258	0	7,427,715
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00 06000	LABORATORY	81	81	0	0	10,615
65.00 06500	RESPIRATORY THERAPY	137	137	79,345	0	107,295
66.00 06600	PHYSICAL THERAPY	4,502	4,502	851,577	0	1,438,857
67.00 06700	OCCUPATIONAL THERAPY	1,200	1,200	715,706	0	919,491
68.00 06800	SPEECH PATHOLOGY	357	357	365,721	0	443,005
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	241,055
74.00 07400	RENAL DIALYSIS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	23,117	23,117	7,777,885	-5,292,146	13,875,710
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00 07950	NONALLOWABLE CASE MANAGER	0	0	527,227	0	597,981
194.01 07951	IDLE SPACE	0	0	0	0	0
194.02 07952	DISTRICT	0	0	0	0	0
194.03 07953	DISTRICT SALES	0	0	0	0	0
194.04 07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0
194.05 07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	0
194.06 07956	CENTRALIZED STAFFING	0	0	0	0	0
194.07 07957	HR MANAGED CARE	0	0	0	0	0
194.08 07959	LACUNA HEALTH	0	0	0	0	0
194.09 07958	SALES & MARKETING	0	0	0	0	0
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0
194.12 07960	VISITOR MEALS	0	0	0	0	0
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,808,764	391,439	983,429		5,292,146
203.00	Unit cost multiplier (Wkst. B, Part I)	78.243890	16.932950	0.118412		0.365639
204.00	Cost to be allocated (per Wkst. B, Part II)			56,725		487,476
205.00	Unit cost multiplier (Wkst. B, Part II)			0.006830		0.033680
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: 15-3044

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

Worksheet B-1

Date/Time Prepared:  
5/20/2024 10:27 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET #3)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET #4)	DIETARY (MEALS SERVED)	CAFETERIA (CAFETERIA FTES)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	20,026				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,576			8.00
9.00	00900	HOUSEKEEPING	269	0	19,757		9.00
10.00	01000	DIETARY	1,820	0	1,820	45,973	10.00
11.00	01100	CAFETERIA	1,899	0	1,899	8,245	68
13.00	01300	NURSING ADMINISTRATION	153	0	153	0	2
14.00	01400	CENTRAL SERVICES & SUPPLY	1,209	0	1,209	0	0
15.00	01500	PHARMACY	413	0	413	0	2
16.00	01600	MEDICAL RECORDS & LIBRARY	137	0	137	0	4
17.00	01700	SOCIAL SERVICE	180	0	180	0	0
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	7,669	12,576	7,669	37,728	37
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00	06000	LABORATORY	81	0	81	0	0
65.00	06500	RESPIRATORY THERAPY	137	0	137	0	1
66.00	06600	PHYSICAL THERAPY	4,502	0	4,502	0	10
67.00	06700	OCCUPATIONAL THERAPY	1,200	0	1,200	0	8
68.00	06800	SPEECH PATHOLOGY	357	0	357	0	4
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,026	12,576	19,757	45,973	68
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	0	0
194.01	07951	IDLE SPACE	0	0	0	0	0
194.02	07952	DISTRICT	0	0	0	0	0
194.03	07953	DISTRICT SALES	0	0	0	0	0
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0
194.05	07955	CENTRALIZED BUSINESS (CBO)	0	0	0	0	0
194.06	07956	CENTRALIZED STAFFING	0	0	0	0	0
194.07	07957	HR MANAGED CARE	0	0	0	0	0
194.08	07959	LACUNA HEALTH	0	0	0	0	0
194.09	07958	SALES & MARKETING	0	0	0	0	0
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0
194.12	07960	VISITOR MEALS	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	990,184	130,165	378,080	1,390,418	626,427
203.00		Unit cost multiplier (Wkst. B, Part I)	49.444922	10.350270	19.136509	30.244230	9,212.161765
204.00		Cost to be allocated (per Wkst. B, Part II)	201,640	3,210	38,546	229,565	250,825
205.00		Unit cost multiplier (Wkst. B, Part II)	10.068910	0.255248	1.951005	4.993474	3,688.602941
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: 15-3044

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

Worksheet B-1

Date/Time Prepared:  
5/20/2024 10:27 am

Cost Center Description		NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	37					13.00
14.00	01400	0	19,287				14.00
15.00	01500	0	11,536	240,890			15.00
16.00	01600	0	257	0	49,681,499		16.00
17.00	01700	0	0	0	0	12,576	17.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	37	812	0	24,541,598	12,576	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	0	0	50.00
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	1,581,881	0	60.00
65.00	06500	0	0	0	302,789	0	65.00
66.00	06600	0	6,682	0	7,825,881	0	66.00
67.00	06700	0	0	0	7,909,999	0	67.00
68.00	06800	0	0	0	5,079,541	0	68.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	240,890	2,439,810	0	73.00
74.00	07400	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		37	19,287	240,890	49,681,499	12,576	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
194.12	07960	0	0	0	0	0	194.12
200.00							200.00
201.00							201.00
202.00		396,068	272,425	703,989	467,747	35,741	202.00
203.00		10,704.540541	14.124799	2.922450	0.009415	2.842001	203.00
204.00		33,852	134,275	145,661	43,312	19,872	204.00
205.00		914.918919	6.961943	0.604678	0.000872	1.580153	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-3044

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

Worksheet B-1

Date/Time Prepared:  
5/20/2024 10:27 am

Cost Center Description		PARAMED ED PRGM (ASSIGNED TIME)	
		23.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
44.00	04400	SKILLED NURSING FACILITY	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
95.00	09500	AMBULANCE SERVICES	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	194.00
194.01	07951	IDLE SPACE	194.01
194.02	07952	DISTRICT	194.02
194.03	07953	DISTRICT SALES	194.03
194.04	07954	CENTRALIZED ADMISSIONS (CAD)	194.04
194.05	07955	CENTRALIZED BUSINESS (CBO)	194.05
194.06	07956	CENTRALIZED STAFFING	194.06
194.07	07957	HR MANAGED CARE	194.07
194.08	07959	LACUNA HEALTH	194.08
194.09	07958	SALES & MARKETING	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	194.11
194.12	07960	VISITOR MEALS	194.12
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	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: 15-3044

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/20/2024 10:27 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		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS		12,955,927		334	12,956,261	30.00
31.00	03100 INTENSIVE CARE UNIT		0		0	0	31.00
44.00	04400 SKILLED NURSING FACILITY		0		0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM		0		0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		0		0	0	54.00
60.00	06000 LABORATORY		34,944		0	34,944	60.00
65.00	06500 RESPIRATORY THERAPY	0	167,985		0	167,985	65.00
66.00	06600 PHYSICAL THERAPY	0	2,533,898		0	2,533,898	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,486,161		0	1,486,161	67.00
68.00	06800 SPEECH PATHOLOGY	0	714,142		0	714,142	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1,056,154		0	1,056,154	73.00
74.00	07400 RENAL DIALYSIS		0		0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC		0		0	0	90.00
91.00	09100 EMERGENCY		0		0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES		0		0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS		0		0	0	98.00
200.00	Subtotal (see instructions)		18,949,211	0	334	18,949,545	200.00
201.00	Less Observation Beds		0		0	0	201.00
202.00	Total (see instructions)		18,949,211	0	334	18,949,545	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-3044

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/20/2024 10:27 am

		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	24,541,598		24,541,598		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	1,581,881	0	1,581,881	0.022090	60.00
65.00	06500	RESPIRATORY THERAPY	302,789	0	302,789	0.0054792	65.00
66.00	06600	PHYSICAL THERAPY	7,825,881	0	7,825,881	0.323784	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,909,999	0	7,909,999	0.187884	67.00
68.00	06800	SPEECH PATHOLOGY	5,079,541	0	5,079,541	0.140592	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,439,810	0	2,439,810	0.0432884	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
200.00		Subtotal (see instructions)	49,681,499	0	49,681,499		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	49,681,499	0	49,681,499		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/20/2024 10:27 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
44.00	04400 SKILLED NURSING FACILITY			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.022090		60.00
65.00	06500 RESPIRATORY THERAPY	0.554792		65.00
66.00	06600 PHYSICAL THERAPY	0.323784		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.187884		67.00
68.00	06800 SPEECH PATHOLOGY	0.140592		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.432884		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
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: 15-3044

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/20/2024 10:27 am

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	12,955,927		12,955,927	334	12,956,261 30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0 31.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0 44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0		0	0	0 50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0		0	0	0 54.00
60.00	06000 LABORATORY	34,944		34,944	0	34,944 60.00
65.00	06500 RESPIRATORY THERAPY	167,985	0	167,985	0	167,985 65.00
66.00	06600 PHYSICAL THERAPY	2,533,898	0	2,533,898	0	2,533,898 66.00
67.00	06700 OCCUPATIONAL THERAPY	1,486,161	0	1,486,161	0	1,486,161 67.00
68.00	06800 SPEECH PATHOLOGY	714,142	0	714,142	0	714,142 68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0 71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,056,154		1,056,154	0	1,056,154 73.00
74.00	07400 RENAL DIALYSIS	0		0	0	0 74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0		0	0	0 90.00
91.00	09100 EMERGENCY	0		0	0	0 91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	0		0	0	0 95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0		0	0	0 98.00
200.00	Subtotal (see instructions)	18,949,211	0	18,949,211	334	18,949,545 200.00
201.00	Less Observation Beds	0		0	0	0 201.00
202.00	Total (see instructions)	18,949,211	0	18,949,211	334	18,949,545 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-3044

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/20/2024 10:27 am

		Title XIX			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	24,541,598		24,541,598		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	1,581,881	0	1,581,881	0.022090	60.00
65.00	06500	RESPIRATORY THERAPY	302,789	0	302,789	0.554792	65.00
66.00	06600	PHYSICAL THERAPY	7,825,881	0	7,825,881	0.323784	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,909,999	0	7,909,999	0.187884	67.00
68.00	06800	SPEECH PATHOLOGY	5,079,541	0	5,079,541	0.140592	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,439,810	0	2,439,810	0.432884	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
200.00		Subtotal (see instructions)	49,681,499	0	49,681,499		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	49,681,499	0	49,681,499		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/20/2024 10:27 am
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-3044		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part I Date/Time Prepared: 5/20/2024 10:27 am	
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)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,501,076	0	1,501,076	12,576	119.36	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (Lines 30 through 199)	1,501,076		1,501,076	12,576		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	5,112	610,168				
31.00	INTENSIVE CARE UNIT	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (Lines 30 through 199)	5,112	610,168				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prepared: 5/20/2024 10:27 am
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Cost Center Description		Title XVIII			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0.000000	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0	0	54.00
60.00	06000 LABORATORY	10,421	1,581,881	0.006588	698,989	4,605	60.00
65.00	06500 RESPIRATORY THERAPY	22,794	302,789	0.075280	104,499	7,867	65.00
66.00	06600 PHYSICAL THERAPY	627,106	7,825,881	0.080132	3,183,144	255,072	66.00
67.00	06700 OCCUPATIONAL THERAPY	200,900	7,909,999	0.025398	3,119,467	79,228	67.00
68.00	06800 SPEECH PATHOLOGY	74,871	5,079,541	0.014740	1,914,295	28,217	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	155,908	2,439,810	0.063902	851,559	54,416	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (lines 50 through 199)	1,092,000	25,139,901		9,871,953	429,405	200.00



APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-3044		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part III Date/Time Prepared: 5/20/2024 10:27 am		
Cost Center Description			Title XVIII			Hospital		PPS	
			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00	
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	12,576	0.00	5,112	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00	
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00	
200.00		Total (lines 30 through 199)		0	12,576		5,112	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
31.00	03100	INTENSIVE CARE UNIT	0						31.00
44.00	04400	SKILLED NURSING FACILITY	0						44.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3044

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/20/2024 10:27 am

Cost Center Description			Title XVIII				Hospital	PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health		
			1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/20/2024 10:27 am
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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		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	0	0	1,581,881	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	302,789	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	7,825,881	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	7,909,999	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	5,079,541	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,439,810	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES					95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	0	25,139,901		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/20/2024 10:27 am
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Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	698,989	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	104,499	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	3,183,144	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	3,119,467	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	1,914,295	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	851,559	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00	Total (Lines 50 through 199)		9,871,953	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/20/2024 10:27 am
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,576	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,576	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)		12,576	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)		5,112	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		12,956,261	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)		12,956,261	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		12,956,261	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,030.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,266,587	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)		5,266,587	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/20/2024 10:27 am		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)					42.00	
Intensive Care Type Inpatient Hospital Units							
43.00	0	0	0.00	0	0	43.00	
44.00						44.00	
45.00						45.00	
46.00						46.00	
47.00						47.00	
Cost Center Description							
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,327,926	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)					7,594,513	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)					610,168	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					429,405	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,039,573	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,554,940	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: 15-3044		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/20/2024 10:27 am	
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	1,501,076	12,956,261	0.115857	0	0	90.00
91.00	Nursing Program cost	0	12,956,261	0.000000	0	0	91.00
92.00	Allied health cost	0	12,956,261	0.000000	0	0	92.00
93.00	All other Medical Education	0	12,956,261	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1
				Date/Time Prepared: 5/20/2024 10:27 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			12,576 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			12,576 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)			12,576 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)			257 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			12,955,927 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)			12,955,927 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			12,955,927 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,030.21 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			264,764 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)			264,764 41.00



COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/20/2024 10:27 am	
Cost Center Description			Title XIX		Hospital	Cost
	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	0	0	0.00	0	0	43.00
44.00						44.00
45.00						45.00
46.00						46.00
47.00						47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				0	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)				0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)				264,764	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
55.01	Permanent adjustment amount per discharge				0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)				0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)				0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	57.00
58.00	Bonus payment (see instructions)				0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)				0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)				0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)				0	61.00
62.00	Relief payment (see instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions				0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3044		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/20/2024 10:27 am	
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	1,501,076	12,955,927	0.115860	0	0	90.00
91.00	Nursing Program cost	0	12,955,927	0.000000	0	0	91.00
92.00	Allied health cost	0	12,955,927	0.000000	0	0	92.00
93.00	All other Medical Education	0	12,955,927	0.000000	0	0	93.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 15-3044

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

Worksheet D-2

Date/Time Prepared:  
5/20/2024 10:27 am

Cost Center Description	Percent of Assigned Time	Expense Allocation	Total Inpatient Day All Patients	Average Cost Per Day	Health Care Program Inpatient Days Title V															
	1.00	2.00	3.00	4.00	5.00															
<b>PART I - NOT IN APPROVED TEACHING PROGRAM</b>																				
1.00	Total cost of services rendered					1.00														
Hospital Inpatient Routine Services:																				
2.00	0.00	0	12,576	0.00	0	2.00														
3.00	0.00	0	0	0.00	0	3.00														
4.00						4.00														
5.00						5.00														
6.00						6.00														
7.00						7.00														
8.00						8.00														
9.00	0.00	0				9.00														
10.00						10.00														
11.00						11.00														
12.00						12.00														
13.00	0.00	0	0	0.00	0	13.00														
14.00						14.00														
15.00						15.00														
16.00						16.00														
17.00						17.00														
18.00						18.00														
19.00						19.00														
20.00	0.00	0				20.00														
<table border="1"> <thead> <tr> <th>Cost Center Description</th> <th></th> <th></th> <th>Total Charges (from Worksheet C, Part I, column 8, lines 88 through 93)</th> <th>Ratio of Cost to Charges (col. 2 ÷ col. 3)</th> <th>Titles V and XIX Outpatient and Title XVIII Part B Charges Title V</th> <th></th> </tr> <tr> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td> </tr> </thead> </table>							Cost Center Description			Total Charges (from Worksheet C, Part I, column 8, lines 88 through 93)	Ratio of Cost to Charges (col. 2 ÷ col. 3)	Titles V and XIX Outpatient and Title XVIII Part B Charges Title V			1.00	2.00	3.00	4.00	5.00	
Cost Center Description			Total Charges (from Worksheet C, Part I, column 8, lines 88 through 93)	Ratio of Cost to Charges (col. 2 ÷ col. 3)	Titles V and XIX Outpatient and Title XVIII Part B Charges Title V															
	1.00	2.00	3.00	4.00	5.00															
Hospital Outpatient Services:																				
21.00						21.00														
22.00						22.00														
23.00	0.00	0	0	0.000000	0	23.00														
24.00	0.00	0	0	0.000000	0	24.00														
25.00						25.00														
26.00						26.00														
27.00	0.00	0				27.00														
28.00	0.00	0				28.00														
<table border="1"> <thead> <tr> <th>Cost Center Description</th> <th>Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22</th> <th>Swing bed Amount</th> <th>Net cost (column 1 plus column 2)</th> <th>Total Inpatient Days - All Patients</th> <th>Average Cost Per Day (col. 3 ÷ col. 4)</th> <th></th> </tr> <tr> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td> </tr> </thead> </table>							Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)			1.00	2.00	3.00	4.00	5.00	
Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)															
	1.00	2.00	3.00	4.00	5.00															
<b>PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)</b>																				
Hospital Inpatient Routine Services:																				
29.00	0	0	0	0	0.00	29.00														
30.00						30.00														
31.00						31.00														
32.00	0	0	0	0	0.00	32.00														
33.00						33.00														
34.00						34.00														
35.00						35.00														
36.00						36.00														
37.00	0		0			37.00														
38.00						38.00														
39.00						39.00														
40.00						40.00														
41.00	0		0	0	0.00	41.00														
42.00	0		0			42.00														

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 15-3044

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

Worksheet D-2

Date/Time Prepared:  
5/20/2024 10:27 am

Cost Center Description	Not In Approved Teaching Program		In Approved Teaching Program	
	(from Part I:)	Amount	(from Part II, col. 7, - )	
	1.00	2.00	3.00	
<b>PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)</b>				
<b>Hospital</b>				
43.00 Inpatient	col. 9, line 9.00		0 line 37.00	43.00
44.00 Outpatient	col. 9, line 27.00		0	44.00
45.00 Total Hospital (sum of lines 43 and 44)			0	45.00
46.00 SUBPROVIDER - IPF				46.00
47.00 SUBPROVIDER - IRF				47.00
48.00 SUBPROVIDER				48.00
49.00 SKILLED NURSING FACILITY	col. 9, line 13.00		0 col. 9, line 41.00	49.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS	Provider CCN: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet D-2 Date/Time Prepared: 5/20/2024 10:27 am
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Cost Center Description	Health Care Program Inpatient Days		Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)		
	Title XVIII, Part B Only Less Part A Coverage but no Part B Coverage	Title XIX					
	6.00	7.00					
<b>PART I - NOT IN APPROVED TEACHING PROGRAM</b>							
1.00	Total cost of services rendered					1.00	
Hospital Inpatient Routine Services:							
2.00	ADULTS & PEDIATRICS	5,112	257	0	0	0	2.00
3.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	CORONARY CARE UNIT						4.00
5.00	BURN INTENSIVE CARE UNIT						5.00
6.00	SURGICAL INTENSIVE CARE UNIT						6.00
7.00	OTHER SPECIAL CARE (SPECIFY)						7.00
8.00	NURSERY						8.00
9.00	Subtotal (sum of lines 2 through 8)			0	0	0	9.00
10.00	SUBPROVIDER - IPF						10.00
11.00	SUBPROVIDER - IRF						11.00
12.00	SUBPROVIDER						12.00
13.00	SKILLED NURSING FACILITY	0	0	0	0	0	13.00
14.00	NURSING FACILITY						14.00
15.00	OTHER LONG TERM CARE						15.00
16.00	HOME HEALTH AGENCY						16.00
17.00	CMHC						17.00
18.00	AMBULATORY SURGICAL CENTER (D.P.)						18.00
19.00	HOSPICE						19.00
20.00	Subtotal (sum of lines 9 through 19)						20.00
Cost Center Description		Titles V and XIX Outpatient and Title XVIII Part B Charges		Titles V and XIX Outpatient and Title XVIII Part B Cost			
		Title XVIII Part B	Title XIX	Title V	Title XVIII Part B	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
Hospital Outpatient Services:							
21.00	RURAL HEALTH CLINIC						21.00
22.00	FEDERALLY QUALIFIED HEALTH CENTER						22.00
23.00	CLINIC	0	0	0	0	0	23.00
24.00	EMERGENCY	0	0	0	0	0	24.00
25.00	OBSERVATION BEDS (NON-DISTINCT PART)						25.00
26.00	OTHER OUTPATIENT SERVICE COST CENTER						26.00
27.00	Subtotal (sum of lines 21 through 26)			0	0	0	27.00
28.00	Total (sum of lines 20 and 27)						28.00
Cost Center Description		Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	PSA Adj. Interns & Residents			
		6.00	7.00	11.00			
<b>PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)</b>							
Hospital Inpatient Routine Services:							
29.00	ADULTS & PEDIATRICS			0			29.00
30.00	Swing Bed - SNF			0			30.00
31.00	Swing Bed - NF						31.00
32.00	INTENSIVE CARE UNIT			0			32.00
33.00	CORONARY CARE UNIT						33.00
34.00	BURN INTENSIVE CARE UNIT						34.00
35.00	SURGICAL INTENSIVE CARE UNIT						35.00
36.00	OTHER SPECIAL CARE (SPECIFY)						36.00
37.00	Subtotal (sum of lines 29, and 32 through 36)			0			37.00
38.00	SUBPROVIDER - IPF						38.00
39.00	SUBPROVIDER - IRF						39.00
40.00	SUBPROVIDER						40.00
41.00	SKILLED NURSING FACILITY			0			41.00
42.00	Total (sum of lines 37 through 41)			0			42.00









CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part III Date/Time Prepared: 5/20/2024 10:27 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)		10,865,375	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0249	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		506,326	3.00
4.00	Outlier Payments		1,670	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)		34.454795	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)		11,373,371	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		0	15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)		0	16.00
17.00	Subtotal (see instructions)		11,373,371	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		11,373,371	19.00
20.00	Deductibles		169,380	20.00
21.00	Subtotal (line 19 minus line 20)		11,203,991	21.00
22.00	Coinsurance		57,189	22.00
23.00	Subtotal (line 21 minus line 22)		11,146,802	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		35,805	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		23,273	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		29,270	26.00
27.00	Subtotal (sum of lines 23 and 25)		11,170,075	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)		11,170,075	32.00
32.01	Sequestration adjustment (see instructions)		223,402	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		10,889,947	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)		56,726	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4		1,670	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00
<b>FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)</b>				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.		0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)		0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part IV Date/Time Prepared: 5/20/2024 10:27 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART IV - MEDICARE PART A SERVICES - LTCH PPS</b>				
1.00	Net Federal PPS Payments (see instructions)		0	1.00
1.01	Full standard payment amount		0	1.01
1.02	Short stay outlier standard payment amount		0	1.02
1.03	Site neutral payment amount - Cost		0	1.03
1.04	Site neutral payment amount - IPPS comparable		0	1.04
2.00	Outlier Payments		0	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		0	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)		0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)			5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)		0	6.00
7.00	Subtotal (see instructions)		0	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8).		0	9.00
10.00	Deductibles		0	10.00
11.00	Subtotal (line 9 minus line 10)		0	11.00
12.00	Coinsurance		0	12.00
13.00	Subtotal (line 11 minus line 12)		0	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		0	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	16.00
17.00	Subtotal (sum of lines 13 and 15)		0	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	18.00
19.00	Other pass through costs (see instructions)		0	19.00
20.00	Outlier payments reconciliation		0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	21.50
21.98	Recovery of accelerated depreciation.		0	21.98
21.99	Demonstration payment adjustment amount before sequestration		0	21.99
22.00	Total amount payable to the provider (see instructions)		0	22.00
22.01	Sequestration adjustment (see instructions)		0	22.01
22.02	Demonstration payment adjustment amount after sequestration		0	22.02
23.00	Interim payments		0	23.00
24.00	Tentative settlement (for contractor use only)		0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)		0	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	26.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)		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 (see instructions)		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-3044	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/20/2024 10:27 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		264,764		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)		264,764	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)		264,764	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		264,764	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		264,764	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS		0	0	37.00
37.01	OTHER ADJUSTMENTS		0	0	37.01
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		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: 15-3044

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

Worksheet G  
Date/Time Prepared:  
5/20/2024 10:27 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	958,278	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	4,399,143	0	0	0	4.00
5.00	Other receivable	-37,719	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-549,427	0	0	0	6.00
7.00	Inventory	127,368	0	0	0	7.00
8.00	Prepaid expenses	224,000	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,121,643	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	866,055	0	0	0	17.00
18.00	Accumulated depreciation	-281,276	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	2,191,692	0	0	0	23.00
24.00	Accumulated depreciation	-1,221,642	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)	1,554,829	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	16,395	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	12,177,460	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	12,193,855	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	18,870,327	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	1,178,131	0	0	0	37.00
38.00	Salaries, wages, and fees payable	504,400	0	0	0	38.00
39.00	Payroll taxes payable	126,790	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,103,955	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,913,276	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	11,473,830	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,473,830	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	14,387,106	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	4,483,221				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)	4,483,221	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	18,870,327	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-3044

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

Worksheet G-1

Date/Time Prepared:  
5/20/2024 10:27 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		3,892,859			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		6,853,380				2.00
3.00	Total (sum of line 1 and line 2)		10,746,239			0	3.00
4.00	Additions (credit adjustments)	0		0		0	4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING	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)		10,746,239			0	11.00
12.00	Deductions (debit adjustments)	0		0		0	12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING	6,263,018		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)		6,263,018			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		4,483,221			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)		0				4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments)		0				12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING		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: 15-3044

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/20/2024 10:27 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	24,491,442		24,491,442	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	0		0	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)	24,491,442		24,491,442	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	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)	24,491,442		24,491,442	17.00
18.00	Ancillary services	25,190,057	0	25,190,057	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	49,681,499	0	49,681,499	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		19,441,523		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)		19,441,523		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-3044

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

Worksheet G-3

Date/Time Prepared:  
5/20/2024 10:27 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	49,681,499	1.00
2.00	Less contractual allowances and discounts on patients' accounts	23,463,310	2.00
3.00	Net patient revenues (line 1 minus line 2)	26,218,189	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	19,441,523	4.00
5.00	Net income from service to patients (line 3 minus line 4)	6,776,666	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	44,631	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	25,818	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	55	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	6,210	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	76,714	25.00
26.00	Total (line 5 plus line 25)	6,853,380	26.00
27.00	OTHER EXPENSES	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)	6,853,380	29.00