

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: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/23/2024 9:53 am
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<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 5/23/2024	Time: 9:53 am
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL OF NOBLE CTY, INC ( 15-0146 ) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	<b>Jeanne Wickens</b>	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Jeanne Wickens		2
3	Signatory Title	CFO		3
4	Date	(Dated when report is electronic)		4

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00	HOSPITAL	0	263,980	30,857	0	0 1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	0 2.00
3.00	SUBPROVIDER - IRF	0	0	0	0	0 3.00
5.00	SWING BED - SNF	0	0	0	0	0 5.00
6.00	SWING BED - NF	0	0	0	0	0 6.00
7.00	SKILLED NURSING FACILITY	0	0	0	0	0 7.00
8.00	NURSING FACILITY	0	0	0	0	0 8.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	0 9.00
10.00	RURAL HEALTH CLINIC I	0	0	0	0	0 10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0 11.00
12.00	CMHC I	0	0	0	0	0 12.00
200.00	TOTAL	0	263,980	30,857	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: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/23/2024 9:53 am
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1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 401 SAWYER ROAD			PO Box: 728						1.00	
2.00	City: KENDALLVILLE			State: IN		Zip Code: 46755-0728		County: NOBLE		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	
								V	XVIII	XIX	
Hospital and Hospital -Based Component Identification:											
3.00	Hospital		COMMUNITY HOSPITAL OF NOBLE CTY, INC	150146	99915	1	05/30/2000	N	P	P	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital -Based SNF										9.00
10.00	Hospital -Based NF										10.00
11.00	Hospital -Based OLTC										11.00
12.00	Hospital -Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital -Based Hospice										14.00
15.00	Hospital -Based Health Clinic - RHC										15.00
16.00	Hospital -Based Health Clinic - FQHC										16.00
17.00	Hospital -Based (CMHC) I										17.00
17.10	Hospital -Based (CORF) I										17.10
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2023	12/31/2023			20.00
21.00	Type of Control (see instructions)						2				21.00
							1.00	2.00	3.00		

Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		N	22.03
22.04	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.									
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)									
22.04	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.									
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: 15-0146			Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/23/2024 9:53 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.	163	20	9	0	858	61		24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0			25.00
						Urban/Rural	S	Date of Geogr	
						1.00		2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					1			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.					01/01/2023	12/31/2023		38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					Y	Y		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.					N			57.00

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		V	XVIII	XIX		
		1.00	2.00	3.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N				60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02
61.03	Enter the 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
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00
62.01	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
<b>Teaching Hospitals that Claim Residents in Nonprovider Settings</b>						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N

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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)							64.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col . 3/ (col . 3 + col . 4))			
			1.00	2.00	3.00			
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)							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)							66.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col . 3/ (col . 3 + col . 4))			
			1.00	2.00	3.00			
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)							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)			N	N	0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00
			1.00				
<b>Long Term Care Hospital PPS</b>							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00	
<b>TEFRA Providers</b>							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N			87.00
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments			
			1.00	2.00			
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.			N		0	88.00
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge		
			1.00	2.00	3.00		
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.			0.00		0	89.00
			V	XIX			
			1.00	2.00			
<b>Title V and XIX Services</b>							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	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: 15-0146		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/23/2024 9:53 am	
				V	XIX		
				1.00	2.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. 1, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y				98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y				98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. 1V, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y				98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N				98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N				98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. 1, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y				98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. 1 through 1V? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y				98.06
<b>Rural Providers</b>							
105.00	Does this hospital qualify as a CAH?	N					105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)						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					109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N				110.00
						1.00	2.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.		N				111.00
						1.00	2.00
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: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/23/2024 9:53 am
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	132,598	2,670	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.		Y	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 Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y	121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.		Y Y	123.00
<b>Certified Transplant Center Information</b>				
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N	125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
<b>All Providers</b>				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y 15H032	140.00
		1.00	2.00	3.00
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name: PARKVIEW HEALTH SYSTEM, INC.	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 10501 CORPORATE DRIVE	PO Box: 5600		142.00
143.00	City: FORT WAYNE	State: IN	Zip Code: 46845-1700	143.00
			1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y	144.00
		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N	146.00



HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0146		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/23/2024 9:53 am			
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
		Part A	Part B	Title V	Title XIX				
		1.00	2.00	3.00	4.00				
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
161.10	CORF		N	N	N	N	161.10		
								1.00	
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
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							9.99	169.00
				Beginning	Ending				
				1.00	2.00				
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
				1.00	2.00				
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0146		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part II Date/Time Prepared: 5/23/2024 9:53 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.							
<b>COMPLETED BY ALL HOSPITALS</b>							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
<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	03/24/2022			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					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)	N		N			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)	Y	05/02/2024	Y	05/02/2024		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		Y			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/23/2024 9:53 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
<b>Provider-Based Physicians</b>					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
<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.	JILL		THOMPSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	PARKVIEW HEALTH SYSTEM, INC.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3373027646		JILL.THOMPSON@PARKVIEW.COM	43.00

		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.	SR FINANCIAL COORDINATOR	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: 15-0146

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/23/2024 9:53 am

Component	Worksheet A Line No.	No. of Beds	Bed Days Avai lable	CAH/REH Hours	I/P Days / O/P Vi sits / Tri ps		
					Ti tle V		
	1.00	2.00	3.00	4.00	5.00		
<b>PART I - STATISTICAL DATA</b>							
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	31	11,315	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)		31	11,315	0.00	0	7.00	
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00	
9.00 CORONARY CARE UNIT	32.00	0	0	0.00	0	9.00	
10.00 BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	10.00	
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	0	0	0.00	0	11.00	
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00	
13.00 NURSERY	43.00				0	13.00	
14.00 Total (see instructions)		31	11,315	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	40.00	0	0		0	16.00	
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00	
18.00 SUBPROVIDER						18.00	
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00	
20.00 NURSING FACILITY	45.00	0	0		0	20.00	
21.00 OTHER LONG TERM CARE	46.00	0	0			21.00	
22.00 HOME HEALTH AGENCY	101.00				0	22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)	115.00					23.00	
24.00 HOSPICE	116.00	0	0			24.00	
24.10 HOSPICE (non-distinct part)	30.00					24.10	
25.00 CMHC - CMHC	99.00				0	25.00	
25.10 CMHC - CORF	99.10				0	25.10	
26.00 RURAL HEALTH CLINIC	88.00				0	26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25	
27.00 Total (sum of lines 14-26)		31				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: 15-0146

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/23/2024 9:53 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
<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)	1,016	123	4,595		1.00
2.00	HMO and other (see instructions)	2,037	887			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)	1,016	123	4,595		7.00
8.00	INTENSIVE CARE UNIT	0	0	0		8.00
9.00	CORONARY CARE UNIT	0	0	0		9.00
10.00	BURN INTENSIVE CARE UNIT	0	0	0		10.00
11.00	SURGICAL INTENSIVE CARE UNIT	0	0	0		11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY		40	462		13.00
14.00	Total (see instructions)	1,016	163	5,057	0.00	219.25
15.00	CAH visits	0	0	0		15.00
15.10	REH hours and visits	0	0	0		15.10
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00
20.00	NURSING FACILITY		0	0	0.00	0.00
21.00	OTHER LONG TERM CARE			0	0.00	0.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)			0	0.00	0.00
24.00	HOSPICE	0	0	0	0.00	0.00
24.10	HOSPICE (non-distinct part)			121		24.10
25.00	CMHC - CMHC	0	0	0	0.00	0.00
25.10	CMHC - CORF	0	0	0	0.00	0.00
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)			0	0.00	0.00
28.00	Observation Bed Days		1,017	2,380	0.00	219.25
29.00	Ambulance Trips	1,409				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	61	103		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: 15-0146

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/23/2024 9:53 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	370	64	1,888	1.00
2.00	HMO and other (see instructions)			367	427		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	370	64	1,888	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY	0.00					20.00
21.00	OTHER LONG TERM CARE	0.00				0	21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	0.00					23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC	0.00					25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC	0.00					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: 15-0146

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/23/2024 9:53 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	18,793,595	7,589,561	26,383,156	599,848.17	43.98
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		40,000	0	40,000	71.91	556.25
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		5,049,359	0	5,049,359	129,402.60	39.02
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		3,940,108	101,334	4,041,442	127,797.54	31.62
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		0	0	0	0.00	0.00
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		5,049,359	0	5,049,359	129,402.60	39.02
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		5,879,230	0	5,879,230		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,610,651	0	1,610,651		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		2,540,202	0	2,540,202		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		



HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0146

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/23/2024 9:53 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	4.00	2,091,993	-2,091,993	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	633,000	8,546,902	9,179,902	136,253.58	67.37	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	432,955	34,452	467,407	12,330.50	37.91	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	462,294	36,787	499,081	20,863.02	23.92	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	486,557	-176,343	310,214	12,426.33	24.96	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	215,060	215,060	8,587.00	25.04	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	538,872	42,880	581,752	10,173.00	57.19	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	719,436	57,248	776,684	11,707.65	66.34	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0146

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/23/2024 9:53 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion 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)	13,744,236	7,589,561	21,333,797	470,445.57	45.35	1.00
2.00	Excluded area salaries (see instructions)	3,940,108	101,334	4,041,442	127,797.54	31.62	2.00
3.00	Subtotal salaries (line 1 minus line 2)	9,804,128	7,488,227	17,292,355	342,648.03	50.47	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,049,359	0	5,049,359	129,402.60	39.02	4.00
5.00	Subtotal wage-related costs (see inst.)	8,419,432	0	8,419,432	0.00	48.69	5.00
6.00	Total (sum of lines 3 thru 5)	23,272,919	7,488,227	30,761,146	472,050.63	65.16	6.00
7.00	Total overhead cost (see instructions)	5,365,107	6,664,993	12,030,100	212,341.08	56.65	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/23/2024 9:53 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	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	417,251	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	1,294,115	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	3,725	6.00
7.00	Employee Managed Care Program Administration Fees	69,138	7.00
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,021,563	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	847,335	9.00
10.00	Dental, Hearing and Vision Plan	104,139	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	19,840	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)	72,872	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	11,425	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	1,568,977	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
<b>OTHER</b>			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	12,255	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	47,246	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,489,881	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: 15-0146

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

Worksheet S-3  
Part V  
Date/Time Prepared:  
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Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	7,489,881	1.00
2.00	Hospital	0	7,489,881	2.00
3.00	SUBPROVIDER - IPF	0	0	3.00
4.00	SUBPROVIDER - IRF	0	0	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	0	0	9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I	0	0	12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC	0	0	16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/23/2024 9:53 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)		0.192067	1.00	
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		3,068,438	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		24,285,253	6.00	
7.00	Medicaid cost (line 1 times line 6)		4,664,396	7.00	
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		1,595,958	8.00	
<b>Children's Health Insurance Program (CHIP) (see instructions for each line)</b>					
9.00	Net revenue from stand-alone CHIP		54,096	9.00	
10.00	Stand-alone CHIP charges		104,059	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		19,986	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		0	12.00	
<b>Other state or local government indigent care program (see instructions for each line)</b>					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		4,182,681	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		30,278,591	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		5,815,518	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		1,632,837	16.00	
<b>Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)</b>					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		3,228,795	19.00	
			<b>Uninsured patients</b>	<b>Insured patients</b>	<b>Total (col. 1 + col. 2)</b>
			<b>1.00</b>	<b>2.00</b>	<b>3.00</b>
<b>Uncompensated care cost (see instructions for each line)</b>					
20.00	Charity care charges and uninsured discounts (see instructions)	5,015,825	1,915,345	6,931,170	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	963,374	1,754,847	2,718,221	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)	963,374	1,754,847	2,718,221	23.00
			1.00		
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0		25.00
25.01	Charges for insured patients' liability (see instructions)		198,653		25.01
26.00	Bad debt amount (see instructions)		4,827,602		26.00
27.00	Medicare reimbursable bad debts (see instructions)		91,500		27.00
27.01	Medicare allowable bad debts (see instructions)		140,769		27.01
28.00	Non-Medicare bad debt amount (see instructions)		4,686,833		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		949,455		29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		3,667,676		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		6,896,471		31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/23/2024 9:53 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)		0.192067	1.00
<b>Medicaid (see instructions for each line)</b>				
2.00	Net revenue from Medicaid			2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			5.00
6.00	Medicaid charges			6.00
7.00	Medicaid cost (line 1 times line 6)			7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)			8.00
<b>Children's Health Insurance Program (CHIP) (see instructions for each line)</b>				
9.00	Net revenue from stand-alone CHIP			9.00
10.00	Stand-alone CHIP charges			10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)			12.00
<b>Other state or local government indigent care program (see instructions for each line)</b>				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			14.00
15.00	State or local indigent care program cost (line 1 times line 14)			15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)			16.00
<b>Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)</b>				
17.00	Private grants, donations, or endowment income restricted to funding charity care			17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
<b>Uncompensated care cost (see instructions for each line)</b>				
20.00	Charity care charges and uninsured discounts (see instructions)	5,015,825	1,915,345	6,931,170
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	963,374	1,754,847	2,718,221
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (see instructions)	963,374	1,754,847	2,718,221
			1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
25.01	Charges for insured patients' liability (see instructions)		198,653	25.01
26.00	Bad debt amount (see instructions)		4,827,602	26.00
27.00	Medicare reimbursable bad debts (see instructions)		91,500	27.00
27.01	Medicare allowable bad debts (see instructions)		140,769	27.01
28.00	Non-Medicare bad debt amount (see instructions)		4,686,833	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		949,455	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		3,667,676	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,667,676	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0146

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

Worksheet A  
Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		1,930,232	1,930,232	-106,922	1,823,310	1.00
2.00	00200		743,294	743,294	210,622	953,916	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	2,091,993	6,299,314	8,391,307	-2,091,993	6,299,314	4.00
5.00	00500	633,000	24,558,079	25,191,079	853,641	26,044,720	5.00
6.00	00600	0	0	0	0	0	6.00
7.00	00700	432,955	683,442	1,116,397	34,452	1,150,849	7.00
8.00	00800	0	163,598	163,598	0	163,598	8.00
9.00	00900	462,294	99,405	561,699	36,787	598,486	9.00
10.00	01000	486,557	246,860	733,417	-282,876	450,541	10.00
11.00	01100	0	-3,838	-3,838	321,593	317,755	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	538,872	4,537	543,409	42,880	586,289	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	719,436	55,008	774,444	57,248	831,692	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	3,080,462	878,851	3,959,313	-856,367	3,102,946	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
43.00	04300	0	0	0	224,921	224,921	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1,113,303	773,978	1,887,281	100,812	1,988,093	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	907,730	907,730	52.00
53.00	05300	0	1,177,222	1,177,222	0	1,177,222	53.00
54.00	05400	1,331,125	958,723	2,289,848	126,098	2,415,946	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	3,018,442	3,018,442	0	3,018,442	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	766,665	179,361	946,026	61,007	1,007,033	65.00
66.00	06600	1,246,355	42,406	1,288,761	-591,410	697,351	66.00
67.00	06700	0	0	0	489,386	489,386	67.00
68.00	06800	0	0	0	201,202	201,202	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	988,256	988,256	-557,010	431,246	71.00
72.00	07200	0	0	0	557,010	557,010	72.00
73.00	07300	0	4,134,808	4,134,808	0	4,134,808	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
76.98	07698	331,407	115,758	447,165	26,371	473,536	76.98
77.00	07700	0	0	0	0	0	77.00
78.00	07800	0	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	46,790	4,289	51,079	3,723	54,802	90.00
91.00	09100	1,572,273	444,499	2,016,772	129,761	2,146,533	91.00
92.00	09200	0	0	0	0	0	92.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0146

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

Worksheet A  
Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500 AMBULANCE SERVICES	3,757,732	825,491	4,583,223	100,559	4,683,782	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
99.00	09900 CMHC	0	0	0	0	0	99.00
99.10	09910 CORF	0	0	0	0	0	99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
105.00	10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	11400 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600 HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	18,611,219	48,322,015	66,933,234	-775	66,932,459	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,261	9,261	0	9,261	190.00
191.00	19100 RESEARCH	0	0	0	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	35,197	1,457	36,654	2,801	39,455	192.00
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951 PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952 OCC HEALTH	0	0	0	0	0	194.02
194.03	07953 FOUNDATION	0	5,800	5,800	0	5,800	194.03
194.04	07954 PHYSICIAN OFFICES	0	0	0	0	0	194.04
194.05	07955 COMMUNITY & VOLUNTEER SERVICES	147,179	37,368	184,547	-2,026	182,521	194.05
194.06	07956 VACANT SPACE	0	0	0	0	0	194.06
200.00	TOTAL (SUM OF LINES 118 through 199)	18,793,595	48,375,901	67,169,496	0	67,169,496	200.00



RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0146

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

Worksheet A  
Date/Time Prepared:  
5/23/2024 9:53 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	-1,480,774	342,536	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	230,439	1,184,355	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,887	6,295,427	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-9,774,060	16,270,660	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-814	1,150,035	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	163,598	8.00
9.00	00900	HOUSEKEEPING	0	598,486	9.00
10.00	01000	DIETARY	-694	449,847	10.00
11.00	01100	CAFETERIA	-218,480	99,275	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	586,289	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	-831,692	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-2,700	3,100,246	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
43.00	04300	NURSERY	0	224,921	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	1,988,093	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	907,730	52.00
53.00	05300	ANESTHESIOLOGY	-1,177,222	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-6	2,415,940	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	3,018,442	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	-210	1,006,823	65.00
66.00	06600	PHYSICAL THERAPY	-1,078	696,273	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	489,386	67.00
68.00	06800	SPEECH PATHOLOGY	0	201,202	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	431,246	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	557,010	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,134,808	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	473,536	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	54,802	90.00
91.00	09100	EMERGENCY	-32,679	2,113,854	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0146

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

Worksheet A  
Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
95.00	09500	AMBULANCE SERVICES	-1,631	4,682,151	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
99.00	09900	CMHC	0	0	99.00
99.10	09910	CORF	0	0	99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
105.00	10500	KIDNEY ACQUISITION	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	115.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,295,488	53,636,971	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,261	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	39,455	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	194.01
194.02	07952	OCC HEALTH	0	0	194.02
194.03	07953	FOUNDATION	0	5,800	194.03
194.04	07954	PHYSICIAN OFFICES	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	182,521	194.05
194.06	07956	VACANT SPACE	0	0	194.06
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,295,488	53,874,008	200.00

RECLASSIFICATIONS

Provider CCN: 15-0146

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

Worksheet A-6

Date/Time Prepared:  
5/23/2024 9:53 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - INTEREST EXPENSE</b>					
1.00		0.00	0	0	1.00
			0	0	
<b>B - REHAB THERAPY</b>					
1.00	OCCUPATIONAL THERAPY	67.00	473,283	16,103	1.00
2.00	SPEECH PATHOLOGY	68.00	194,582	6,620	2.00
			667,865	22,723	
<b>C - INSURANCE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	54,921	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	48,779	2.00
			0	103,700	
<b>F - CLINIC DIETICIAN</b>					
1.00		0.00	0	0	1.00
			0	0	
<b>G - EMPLOYEE SALARY BENEFITS</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	957,341	0	1.00
2.00	OPERATION OF PLANT	7.00	34,452	0	2.00
3.00	HOUSEKEEPING	9.00	36,787	0	3.00
4.00	DIETARY	10.00	38,717	0	4.00
5.00	NURSING ADMINISTRATION	13.00	42,880	0	5.00
6.00	PHARMACY	15.00	57,248	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	276,284	0	7.00
8.00	OPERATING ROOM	50.00	100,812	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	126,098	0	9.00
10.00	RESPIRATORY THERAPY	65.00	61,007	0	10.00
11.00	PHYSICAL THERAPY	66.00	99,178	0	11.00
12.00	HYPERBARIC OXYGEN THERAPY	76.98	26,371	0	12.00
13.00	CLINIC	90.00	3,723	0	13.00
14.00	EMERGENCY	91.00	129,761	0	14.00
15.00	AMBULANCE SERVICES	95.00	100,559	0	15.00
16.00	PHYSICIANS' PRIVATE OFFICES	192.00	2,801	0	16.00
17.00	COMMUNITY & VOLUNTEER SERVICES	194.05	0	0	17.00
			2,094,019	0	
<b>H - CAFETERIA</b>					
1.00	CAFETERIA	11.00	215,060	106,533	1.00
			215,060	106,533	
<b>I - DEPRECIATION</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	161,843	1.00
			0	161,843	
<b>J - HOME OFFICE SALARIES</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	7,589,561	0	1.00
			7,589,561	0	
<b>K - LAUNDRY</b>					
1.00		0.00	0	0	1.00
			0	0	
<b>M - IMPLANTS</b>					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	557,010	1.00
			0	557,010	
<b>N - OB</b>					
1.00	NURSERY	43.00	159,466	65,455	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	643,567	264,163	2.00
			803,033	329,618	
<b>P - OTHER</b>					
1.00		0.00	0	0	1.00
			0	0	
<b>Q - PERSONAL PROP TAX</b>					
1.00		0.00	0	0	1.00
			0	0	
500.00	Grand Total: Increases		11,369,538	1,281,427	500.00

RECLASSIFICATIONS

Provider CCN: 15-0146

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

Worksheet A-6

Date/Time Prepared:  
5/23/2024 9:53 am

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
<b>A - INTEREST EXPENSE</b>						
1.00		0.00	0	0	0	1.00
			0	0		
<b>B - REHAB THERAPY</b>						
1.00	PHYSICAL THERAPY	66.00	667,865	22,723	0	1.00
2.00		0.00	0	0	0	2.00
			667,865	22,723		
<b>C - INSURANCE</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	103,700	12	1.00
2.00		0.00	0	0	12	2.00
			0	103,700		
<b>F - CLINIC DIETICIAN</b>						
1.00		0.00	0	0	0	1.00
			0	0		
<b>G - EMPLOYEE SALARY BENEFITS</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2,091,993	0	0	1.00
2.00	COMMUNITY & VOLUNTEER SERVICES	194.05	2,026	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
			2,094,019	0		
<b>H - CAFETERIA</b>						
1.00	DIETARY	10.00	215,060	106,533	0	1.00
			215,060	106,533		
<b>I - DEPRECIATION</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	161,843	9	1.00
			0	161,843		
<b>J - HOME OFFICE SALARIES</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,589,561	0	1.00
			0	7,589,561		
<b>K - LAUNDRY</b>						
1.00		0.00	0	0	0	1.00
			0	0		
<b>M - IMPLANTS</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	557,010	0	1.00
			0	557,010		
<b>N - OB</b>						
1.00	ADULTS & PEDIATRICS	30.00	803,033	329,618	0	1.00
2.00		0.00	0	0	0	2.00
			803,033	329,618		
<b>P - OTHER</b>						
1.00		0.00	0	0	0	1.00
			0	0		
<b>Q - PERSONAL PROP TAX</b>						
1.00		0.00	0	0	0	1.00
			0	0		
500.00	Grand Total: Decreases		3,779,977	8,870,988		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0146

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/23/2024 9:53 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	755,392	0	0	0	2.00
3.00	Buildings and Fixtures	4,270,602	0	0	0	3.00
4.00	Building Improvements	21,157	0	0	0	4.00
5.00	Fixed Equipment	900,581	0	0	0	5.00
6.00	Movable Equipment	14,448,659	1,764,566	0	1,764,566	6.00
7.00	HIT designated Assets	3,173,747	162,883	0	162,883	7.00
8.00	Subtotal (sum of lines 1-7)	23,570,138	1,927,449	0	1,927,449	8.00
9.00	Reconciling Items	3,173,747	162,883	0	162,883	9.00
10.00	Total (line 8 minus line 9)	20,396,391	1,764,566	0	1,764,566	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	755,392	354,030			2.00
3.00	Buildings and Fixtures	4,270,602	795,986			3.00
4.00	Building Improvements	21,157	21,157			4.00
5.00	Fixed Equipment	900,581	94,324			5.00
6.00	Movable Equipment	15,321,687	8,485,280			6.00
7.00	HIT designated Assets	3,336,630	0			7.00
8.00	Subtotal (sum of lines 1-7)	24,606,049	9,750,777			8.00
9.00	Reconciling Items	3,336,630	0			9.00
10.00	Total (line 8 minus line 9)	21,269,419	9,750,777			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0146

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/23/2024 9:53 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	399,040	1,531,192	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	670,834	55,325	14,085	0	3,050	2.00
3.00	Total (sum of lines 1-2)	1,069,874	1,586,517	14,085	0	3,050	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	1,930,232				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	743,294				2.00
3.00	Total (sum of lines 1-2)	0	2,673,526				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet A-7 Part III Date/Time Prepared: 5/23/2024 9:53 am
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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	5,947,732	0	5,947,732	0.244483	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	18,658,318	278,215	18,380,103	0.755517	0	2.00
3.00	Total (sum of lines 1-2)	24,606,050	278,215	24,327,835	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	-1,243,577	1,531,192	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,063,116	55,325	2.00
3.00	Total (sum of lines 1-2)	0	0	0	-180,461	1,586,517	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	54,921	0	0	342,536	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,085	48,779	3,050	0	1,184,355	2.00
3.00	Total (sum of lines 1-2)	14,085	103,700	3,050	0	1,526,891	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0146

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

Worksheet A-8

Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			3.00	4.00	5.00	
1.00	2.00	3.00	4.00	5.00		
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			OCAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			OCAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-11,597	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-763	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	-1,209,901			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	-5,672,241			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	A	-51,777	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts		0		0.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			OUTLITIZATION REVIEW-SNF	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			OCAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			OCAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			ONONPHYSICIAN ANESTHETISTS	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		OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			OADULTS & PEDIATRICS	30.00		30.99



ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0146

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

Worksheet A-8

Date/Time Prepared:  
5/23/2024 9:53 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
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.00
33.01	TELEPHONE	A	-3,887		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.05	PHARMACY SALES	B	-829,533		PHARMACY	15.00	0	33.05
33.06	SELF INSURANCE	A			EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.09	LOBBY DUES	A	-6,467		ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.14	INTERUNIT SUBSIDY	A	-1,526,264		CAP REL COSTS-BLDG & FIXT	1.00	9	33.14
33.18	OTHER OPERATING REVENUE	B			OPERATION OF PLANT	7.00	0	33.18
33.20	OTHER OPERATING REVENUE	B	-694		DIETARY	10.00	0	33.20
33.21	OTHER OPERATING REVENUE	B	-166,703		CAFETERIA	11.00	0	33.21
33.23	OTHER OPERATING REVENUE	B	-2,159		PHARMACY	15.00	0	33.23
33.24	OTHER OPERATING REVENUE	B	-2,700		ADULTS & PEDIATRICS	30.00	0	33.24
33.25	OTHER OPERATING REVENUE	B	-6		RADIOLOGY-DIAGNOSTIC	54.00	0	33.25
33.26	OTHER OPERATING REVENUE	B	-210		RESPIRATORY THERAPY	65.00	0	33.26
33.27	OTHER OPERATING REVENUE	B	-1,078		PHYSICAL THERAPY	66.00	0	33.27
33.30	OTHER OPERATING REVENUE	B	-1,631		AMBULANCE SERVICES	95.00	0	33.30
33.31	OTHER OPERATING REVENUE	B			COMMUNITY & VOLUNTEER SERVICES	194.05	0	33.31
33.33	ADMIN PHYS SALARIES	A	38,556		ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	LOBBYING EXPENSE	A			PHYSICAL THERAPY	66.00	0	33.34
33.35	LOBBYING EXPENSE	A	-2,442		ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	HOSPITAL ASSESSMENT FEE	A	-4,119,869		ADMINISTRATIVE & GENERAL	5.00	0	33.36
33.37	DEPRECIATION RELI FING ADJUSTMENT-BLD	A	45,490		CAP REL COSTS-BLDG & FIXT	1.00	9	33.37
33.38	DEPRECIATION RELI FING ADJUSTMENT-EQU	A	230,439		CAP REL COSTS-MVBLE EQUIP	2.00	9	33.38
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,295,488					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: 15-0146

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

Worksheet A-8-1

Date/Time Prepared:  
5/23/2024 9:53 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	14,048,332	11,377,727 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	PPG SUBSIDY	0	7,881,810 2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE ELIMINATION	0	461,036 3.00
4.00	0.00			0	0 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			14,048,332	19,720,573 5.00

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

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

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

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

6.00	B	0.00	PARKVIEW HEALTH	100.00	6.00
7.00		0.00		0.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Date/Time Prepared: 5/23/2024 9:53 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	2,670,605	0		1.00
2.00	-7,881,810	0		2.00
3.00	-461,036	0		3.00
4.00	0	0		4.00
5.00	-5,672,241			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		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0146

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

Worksheet A-8-2

Date/Time Prepared:  
5/23/2024 9:53 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	53.00	DR. A	1,177,222	1,177,222	0	239,400	0	1.00
2.00	91.00	DR. B	40,000	0	40,000	211,500	72	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			1,217,222	1,177,222	40,000		72	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	53.00	DR. A	0	0	0	0	0	1.00
2.00	91.00	DR. B	7,321	366	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			7,321	366	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	53.00	DR. A	0	0	0	1,177,222		1.00
2.00	91.00	DR. B	0	7,321	32,679	32,679		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	7,321	32,679	1,209,901		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2024 9:53 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			
		1.00	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS-BLDG & FIXT	342,536	342,536				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	1,184,355		1,184,355			2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	6,295,427	0	0	6,295,427		4.00
5.00 00500 ADMINISTRATIVE & GENERAL	16,270,660	74,039	13,378	2,190,473	18,548,550	5.00
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700 OPERATION OF PLANT	1,150,035	28,606	26,754	111,530	1,316,925	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	163,598	2,461	0	0	166,059	8.00
9.00 00900 HOUSEKEEPING	598,486	3,560	3,727	119,088	724,861	9.00
10.00 01000 DIETARY	449,847	7,865	10,122	74,022	541,856	10.00
11.00 01100 CAFETERIA	99,275	4,740	0	51,317	155,332	11.00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300 NURSING ADMINISTRATION	586,289	997	102	138,815	726,203	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	9,155	0	0	9,155	14.00
15.00 01500 PHARMACY	0	2,700	3,397	185,328	191,425	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	4,124	0	0	4,124	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00 02000 NURSING PROGRAM	0	0	0	0	0	20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	3,100,246	43,059	95,527	609,354	3,848,186	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00 04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00 04300 NURSERY	224,921	619	7,333	38,051	270,924	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00 04500 NURSING FACILITY	0	0	0	0	0	45.00
46.00 04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	1,988,093	45,047	157,605	289,706	2,480,451	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	907,730	3,975	29,592	153,565	1,094,862	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,415,940	21,773	360,951	347,715	3,146,379	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	3,018,442	8,320	0	0	3,026,762	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	1,006,823	5,307	88,428	197,495	1,298,053	65.00
66.00 06600 PHYSICAL THERAPY	696,273	22,941	9,069	161,702	889,985	66.00
67.00 06700 OCCUPATIONAL THERAPY	489,386	0	0	112,932	602,318	67.00
68.00 06800 SPEECH PATHOLOGY	201,202	0	0	46,430	247,632	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	431,246	0	0	0	431,246	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	557,010	0	0	0	557,010	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4,134,808	0	0	0	4,134,808	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.98 07698 HYPERBARIC OXYGEN THERAPY	473,536	4,226	13,331	85,371	576,464	76.98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	54,802	0	0	12,053	66,855	90.00
91.00 09100 EMERGENCY	2,113,854	18,032	35,910	406,131	2,573,927	91.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2024 9:53 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			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 09500 AMBULANCE SERVICES	4,682,151	0	328,068	920,646	5,930,865	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
99.00 09900 CMHC	0	0	0	0	0	99.00
99.10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 11600 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	53,636,971	311,546	1,183,294	6,251,724	53,561,217	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,261	2,513	82	0	11,856	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	39,455	16,195	202	9,067	64,919	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 07951 PAIN CLINIC	0	0	0	0	0	194.01
194.02 07952 OCC HEALTH	0	0	0	0	0	194.02
194.03 07953 FOUNDATION	5,800	0	0	0	5,800	194.03
194.04 07954 PHYSICIAN OFFICES	0	0	0	0	0	194.04
194.05 07955 COMMUNITY & VOLUNTEER SERVICES	182,521	12,282	777	34,636	230,216	194.05
194.06 07956 VACANT SPACE	0	0	0	0	0	194.06
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	53,874,008	342,536	1,184,355	6,295,427	53,874,008	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Prepared: 5/23/2024 9:53 am		
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
			5.00	6.00	7.00	8.00	9.00
<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	18,548,550				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	691,486	0	2,008,411		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	87,194	0	20,603	273,856	8.00
9.00	00900	HOUSEKEEPING	380,607	0	29,802	0	1,135,270
10.00	01000	DIETARY	284,516	0	65,847	0	38,179
11.00	01100	CAFETERIA	81,561	0	39,687	0	23,011
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	381,312	0	8,345	0	4,839
14.00	01400	CENTRAL SERVICES & SUPPLY	4,807	0	76,649	8,354	44,442
15.00	01500	PHARMACY	100,513	0	22,601	0	13,104
16.00	01600	MEDICAL RECORDS & LIBRARY	2,165	0	34,526	0	20,019
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING PROGRAM	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	2,020,590	0	360,496	106,184	209,019
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
43.00	04300	NURSERY	142,256	0	5,182	1,713	3,005
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00	04500	NURSING FACILITY	0	0	0	0	0
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,302,425	0	377,148	59,807	218,674
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	574,886	0	33,278	1,714	19,295
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,652,088	0	182,288	27,509	105,692
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	1,589,280	0	69,656	0	40,387
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	681,576	0	44,432	1,685	25,762
66.00	06600	PHYSICAL THERAPY	467,310	0	192,069	0	111,363
67.00	06700	OCCUPATIONAL THERAPY	316,263	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	130,026	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	226,437	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	292,473	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,171,088	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	302,687	0	35,380	396	20,513
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	35,104	0	0	0	0
91.00	09100	EMERGENCY	1,351,507	0	150,966	64,432	87,532
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
95.00	09500	AMBULANCE SERVICES	3,114,155	0	0	0	0
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
99.00	09900 CMHC	0	0	0	0	0	99.00
99.10	09910 CORF	0	0	0	0	0	99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
105.00	10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF						114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600 HOSPICE	0	0	0	0	0	116.00
118.00	11800 SUBTOTALS (SUM OF LINES 1 through 117)	18,384,312	0	1,748,955	271,794	984,836	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,225	0	21,040	0	12,199	190.00
191.00	19100 RESEARCH	0	0	0	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	34,087	0	135,587	2,062	78,614	192.00
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951 PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952 OCC HEALTH	0	0	0	0	0	194.02
194.03	07953 FOUNDATION	3,045	0	0	0	0	194.03
194.04	07954 PHYSICIAN OFFICES	0	0	0	0	0	194.04
194.05	07955 COMMUNITY & VOLUNTEER SERVICES	120,881	0	102,829	0	59,621	194.05
194.06	07956 VACANT SPACE	0	0	0	0	0	194.06
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	20200 TOTAL (sum lines 118 through 201)	18,548,550	0	2,008,411	273,856	1,135,270	202.00



COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
<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
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	930,398					10.00
11.00	01100	0	299,591				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	7,460	0	1,128,159		13.00
14.00	01400	0	0	0	0	143,407	14.00
15.00	01500	0	8,585	0	0	1,847	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	930,398	48,475	0	445,682	17,510	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
43.00	04300	0	2,981	0	27,406	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	20,582	0	189,230	23,132	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	12,031	0	110,613	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	27,849	0	0	4,791	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	15,755	0	0	4,879	65.00
66.00	06600	0	10,525	0	0	854	66.00
67.00	06700	0	8,610	0	0	0	67.00
68.00	06800	0	3,540	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	50,064	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	3,180	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
76.98	07698	0	8,138	0	74,821	5,330	76.98
77.00	07700	0	0	0	0	0	77.00
78.00	07800	0	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	851	0	0	217	90.00
91.00	09100	0	30,499	0	280,407	15,946	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	87,792	0	0	15,135	95.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	930,398	293,673	0	1,128,159	142,885	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	443	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,268	0	0	60	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	4,650	0	0	19	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
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)	930,398	299,591	0	1,128,159	143,407	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Prepared: 5/23/2024 9:53 am
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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
		15.00	16.00	17.00	19.00	20.00	
<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
6.00	00600						6.00
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
12.00	01200						12.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500	338,075					15.00
16.00	01600	0	60,834				16.00
17.00	01700	0	0	0			17.00
19.00	01900	0	0	0	0		19.00
20.00	02000	0	0	0		0	20.00
21.00	02100	0	0	0			21.00
22.00	02200	0	0	0			22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	3,746	0	0	0	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
43.00	04300	0	196	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	6,278	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	790	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	9,939	0	0	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	9,075	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	3,250	0	0	0	65.00
66.00	06600	0	1,085	0	0	0	66.00
67.00	06700	0	351	0	0	0	67.00
68.00	06800	0	250	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	660	0	0	0	71.00
72.00	07200	0	723	0	0	0	72.00
73.00	07300	338,075	5,952	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
76.98	07698	0	1,107	0	0	0	76.98
77.00	07700	0	0	0	0	0	77.00
78.00	07800	0	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	59	0	0	0	90.00
91.00	09100	0	12,048	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	5,325	0	0	0	95.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

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

Worksheet B  
Part I  
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5/23/2024 9:53 am

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	338,075	60,834	0	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
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)	338,075	60,834	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
	21.00	22.00			
<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
6.00 00600 MAINTENANCE & REPAIRS					6.00
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
12.00 01200 MAINTENANCE OF PERSONNEL					12.00
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
19.00 01900 NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000 NURSING PROGRAM					20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0				21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD		0			22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 03000 ADULTS & PEDIATRICS	0	0	7,990,286	0	7,990,286
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	31.00
32.00 03200 CORONARY CARE UNIT	0	0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
40.00 04000 SUBPROVIDER - IPF	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	41.00
43.00 04300 NURSERY	0	0	453,663	0	453,663
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00 04500 NURSING FACILITY	0	0	0	0	45.00
46.00 04600 OTHER LONG TERM CARE	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0	0	4,677,727	0	4,677,727
51.00 05100 RECOVERY ROOM	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1,847,469	0	1,847,469
53.00 05300 ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	5,156,535	0	5,156,535
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	4,735,160	0	4,735,160
60.01 06001 BLOOD LABORATORY	0	0	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	2,075,392	0	2,075,392
66.00 06600 PHYSICAL THERAPY	0	0	1,673,191	0	1,673,191
67.00 06700 OCCUPATIONAL THERAPY	0	0	927,542	0	927,542
68.00 06800 SPEECH PATHOLOGY	0	0	381,448	0	381,448
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	708,407	0	708,407
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	850,206	0	850,206
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	6,653,103	0	6,653,103
74.00 07400 RENAL DIALYSIS	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	1,024,836	0	1,024,836
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000 CLINIC	0	0	103,086	0	103,086
91.00 09100 EMERGENCY	0	0	4,567,264	0	4,567,264

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0146

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

Worksheet B  
Part I  
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5/23/2024 9:53 am

Cost Center Description			INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS				
			21.00	22.00				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	9,153,272	0	9,153,272	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE						116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	52,978,587	0	52,978,587	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	51,763	0	51,763	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	316,597	0	316,597	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	8,845	0	8,845	194.03
194.04	07954	PHYSICIAN OFFICES	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	518,216	0	518,216	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	53,874,008	0	53,874,008	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/23/2024 9:53 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,116,278	74,039	13,378	2,203,695	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	28,606	26,754	55,360	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	2,461	0	2,461	8.00
9.00 00900	HOUSEKEEPING	0	3,560	3,727	7,287	9.00
10.00 01000	DIETARY	0	7,865	10,122	17,987	10.00
11.00 01100	CAFETERIA	0	4,740	0	4,740	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	997	102	1,099	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	9,155	0	9,155	14.00
15.00 01500	PHARMACY	0	2,700	3,397	6,097	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	4,124	0	4,124	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING PROGRAM	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	43,059	95,527	138,586	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00 04300	NURSERY	0	619	7,333	7,952	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
46.00 04600	OTHER LONG TERM CARE	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	45,047	157,605	202,652	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	3,975	29,592	33,567	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	21,773	360,951	382,724	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	0	8,320	0	8,320	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	5,307	88,428	93,735	65.00
66.00 06600	PHYSICAL THERAPY	0	22,941	9,069	32,010	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	4,226	13,331	17,557	76.98
77.00 07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	77.00
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	18,032	35,910	53,942	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0146

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2024 9:53 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>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 09500 AMBULANCE SERVICES	0	0	328,068	328,068	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
99.00 09900 CMHC	0	0	0	0	0	99.00
99.10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 11600 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2,116,278	311,546	1,183,294	3,611,118	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,513	82	2,595	0	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	16,195	202	16,397	0	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 07951 PAIN CLINIC	0	0	0	0	0	194.01
194.02 07952 OCC HEALTH	0	0	0	0	0	194.02
194.03 07953 FOUNDATION	0	0	0	0	0	194.03
194.04 07954 PHYSICIAN OFFICES	0	0	0	0	0	194.04
194.05 07955 COMMUNITY & VOLUNTEER SERVICES	0	12,282	777	13,059	0	194.05
194.06 07956 VACANT SPACE	0	0	0	0	0	194.06
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)	2,116,278	342,536	1,184,355	3,643,169	0	202.00



ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/23/2024 9:53 am			
Cost Center	Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
<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	2,203,695				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	82,154	0	137,514		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,359	0	1,411	14,231	8.00
9.00	00900	HOUSEKEEPING	45,219	0	2,041	0	54,547
10.00	01000	DIETARY	33,803	0	4,509	0	1,834
11.00	01100	CAFETERIA	9,690	0	2,717	0	1,106
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	45,303	0	571	0	232
14.00	01400	CENTRAL SERVICES & SUPPLY	571	0	5,248	434	2,135
15.00	01500	PHARMACY	11,942	0	1,547	0	630
16.00	01600	MEDICAL RECORDS & LIBRARY	257	0	2,364	0	962
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING PROGRAM	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	240,061	0	24,683	5,517	10,043
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
43.00	04300	NURSERY	16,901	0	355	89	144
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00	04500	NURSING FACILITY	0	0	0	0	0
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	154,738	0	25,823	3,108	10,506
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	68,301	0	2,278	89	927
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	196,281	0	12,481	1,430	5,078
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	188,818	0	4,769	0	1,941
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	80,976	0	3,042	88	1,238
66.00	06600	PHYSICAL THERAPY	55,520	0	13,151	0	5,351
67.00	06700	OCCUPATIONAL THERAPY	37,574	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	15,448	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,902	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,748	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	257,942	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	35,962	0	2,422	21	986
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	4,171	0	0	0	0
91.00	09100	EMERGENCY	160,569	0	10,337	3,348	4,206
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
95.00	09500	AMBULANCE SERVICES	369,971	0	0	0	0
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0146

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		<b>SUBTOTALS (SUM OF LINES 1 through 117)</b>	<b>2,184,181</b>	<b>0</b>	<b>119,749</b>	<b>14,124</b>	<b>47,319</b>	<b>118.00</b>
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	740	0	1,441	0	586	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,050	0	9,283	107	3,777	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	362	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	14,362	0	7,041	0	2,865	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		<b>TOTAL (sum lines 118 through 201)</b>	<b>2,203,695</b>	<b>0</b>	<b>137,514</b>	<b>14,231</b>	<b>54,547</b>	<b>202.00</b>

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0146

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

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Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
<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
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	58,133					10.00
11.00	01100	0	18,253				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	454	0	47,659		13.00
14.00	01400	0	0	0	0	17,543	14.00
15.00	01500	0	523	0	0	226	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	58,133	2,953	0	18,827	2,142	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
43.00	04300	0	182	0	1,158	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	1,254	0	7,994	2,830	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	733	0	4,673	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	1,697	0	0	586	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	960	0	0	597	65.00
66.00	06600	0	641	0	0	105	66.00
67.00	06700	0	525	0	0	0	67.00
68.00	06800	0	216	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	6,123	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	389	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
76.98	07698	0	496	0	3,161	652	76.98
77.00	07700	0	0	0	0	0	77.00
78.00	07800	0	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	52	0	0	27	90.00
91.00	09100	0	1,858	0	11,846	1,951	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	5,349	0	0	1,852	95.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0146

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	58,133	17,893	0	47,659	17,480	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	54	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	77	0	0	7	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	283	0	0	2	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	58,133	18,253	0	47,659	17,543	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/23/2024 9:53 am		
Cost Center	Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
		15.00	16.00	17.00	19.00	20.00	
<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
6.00	00600	MAINTENANCE & REPAIRS					6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	20,965				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,707			16.00
17.00	01700	SOCIAL SERVICE	0	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0		22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	475	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
32.00	03200	CORONARY CARE UNIT	0	0	0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0		34.00
40.00	04000	SUBPROVIDER - I PF	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
43.00	04300	NURSERY	0	25	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	795	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	100	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,259	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	1,150	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	412	0		65.00
66.00	06600	PHYSICAL THERAPY	0	137	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	44	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	32	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	84	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	92	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,965	754	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	140	0		76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0		77.00
78.00	07800	CART-CELL IMMUNOTHERAPY	0	0	0		78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	7	0		90.00
91.00	09100	EMERGENCY	0	1,526	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0		94.00
95.00	09500	AMBULANCE SERVICES	0	675	0		95.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/23/2024 9:53 am
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Cost Center Description			PHARMACY	MEDI CAL RECORDS & LIBRARY	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	NURSI NG PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
96.00	09600	DURABLE MEDI CAL EQUI P-RENTED	0	0	0			96.00
97.00	09700	DURABLE MEDI CAL EQUI P-SOLD	0	0	0			97.00
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
100.00	10000	I & R SERVI CES-NOT APPRVD PRGM	0	0	0			100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
102.00	10200	OPIOI D TREATMENT PROGRAM	0	0	0			102.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KI DNEY ACQUI SI TION	0	0	0			105.00
106.00	10600	HEART ACQUI SI TION	0	0	0			106.00
107.00	10700	LI VER ACQUI SI TION	0	0	0			107.00
108.00	10800	LUNG ACQUI SI TION	0	0	0			108.00
109.00	10900	PANCREAS ACQUI SI TION	0	0	0			109.00
110.00	11000	I NTESTI NAL ACQUI SI TION	0	0	0			110.00
111.00	11100	I SLET ACQUI SI TION	0	0	0			111.00
113.00	11300	I NTEREST EXPENSE						113.00
114.00	11400	UTI LI ZATI ON REVI EW-SNF						114.00
115.00	11500	AMBULATORY SURGI CAL CENTER (D. P.)	0	0	0			115.00
116.00	11600	HOSPI CE	0	0	0			116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,965	7,707	0	0	0	118.00
NONREI MBURSABLE COST CENTERS								
190.00	19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
191.00	19100	RESEARCH	0	0	0			191.00
192.00	19200	PHYSI CI ANS' PRI VATE OFFI CES	0	0	0			192.00
193.00	19300	NONPAI D WORKERS	0	0	0			193.00
194.00	07950	OTHER NONREI MBURSABLE COST CENTERS	0	0	0			194.00
194.01	07951	PAI N CLI NI C	0	0	0			194.01
194.02	07952	OCC HEALTH	0	0	0			194.02
194.03	07953	FOUNDATI ON	0	0	0			194.03
194.04	07954	PHYSI CI AN OFFI CES	0	0	0			194.04
194.05	07955	COMMUNI TY & VOLUNTEER SERVI CES	0	0	0			194.05
194.06	07956	VACANT SPACE	0	0	0			194.06
200.00		Cross Foot Adjustments				0		0 200.00
201.00		Negati ve Cost Centers	0	0	0	0		0 201.00
202.00		TOTAL (sum lines 118 through 201)	20,965	7,707	0	0	0	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/23/2024 9:53 am
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Cost Center Description	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
	21.00	22.00			
<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
6.00 00600	MAINTENANCE & REPAIRS				6.00
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
12.00 01200	MAINTENANCE OF PERSONNEL				12.00
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
19.00 01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00 02000	NURSING PROGRAM				20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		0		22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 03000	ADULTS & PEDIATRICS		501,420	0	501,420
31.00 03100	INTENSIVE CARE UNIT		0	0	0
32.00 03200	CORONARY CARE UNIT		0	0	0
33.00 03300	BURN INTENSIVE CARE UNIT		0	0	0
34.00 03400	SURGICAL INTENSIVE CARE UNIT		0	0	0
40.00 04000	SUBPROVIDER - IPF		0	0	0
41.00 04100	SUBPROVIDER - IRF		0	0	0
43.00 04300	NURSERY		26,806	0	26,806
44.00 04400	SKILLED NURSING FACILITY		0	0	0
45.00 04500	NURSING FACILITY		0	0	0
46.00 04600	OTHER LONG TERM CARE		0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000	OPERATING ROOM		409,700	0	409,700
51.00 05100	RECOVERY ROOM		0	0	0
52.00 05200	DELIVERY ROOM & LABOR ROOM		110,668	0	110,668
53.00 05300	ANESTHESIOLOGY		0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC		601,536	0	601,536
55.00 05500	RADIOLOGY-THERAPEUTIC		0	0	0
56.00 05600	RADIOISOTOPE		0	0	0
57.00 05700	CT SCAN		0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0
59.00 05900	CARDIAC CATHETERIZATION		0	0	0
60.00 06000	LABORATORY		204,998	0	204,998
60.01 06001	BLOOD LABORATORY		0	0	0
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0
63.00 06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0
64.00 06400	INTRAVENOUS THERAPY		0	0	0
65.00 06500	RESPIRATORY THERAPY		181,048	0	181,048
66.00 06600	PHYSICAL THERAPY		106,915	0	106,915
67.00 06700	OCCUPATIONAL THERAPY		38,143	0	38,143
68.00 06800	SPEECH PATHOLOGY		15,696	0	15,696
69.00 06900	ELECTROCARDIOLOGY		0	0	0
70.00 07000	ELECTROENCEPHALOGRAPHY		0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		33,109	0	33,109
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS		34,840	0	34,840
73.00 07300	DRUGS CHARGED TO PATIENTS		280,050	0	280,050
74.00 07400	RENAL DIALYSIS		0	0	0
75.00 07500	ASC (NON-DISTINCT PART)		0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY		61,397	0	61,397
77.00 07700	ALLOGENEIC STEM CELL ACQUISITION		0	0	0
78.00 07800	CAR T-CELL IMMUNOTHERAPY		0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800	RURAL HEALTH CLINIC		0	0	0
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0
90.00 09000	CLINIC		4,257	0	4,257
91.00 09100	EMERGENCY		249,583	0	249,583

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0146

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS				
	21.00	22.00				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS			0	0	0	94.00
95.00 09500 AMBULANCE SERVICES			705,915	0	705,915	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED			0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD			0	0	0	97.00
99.00 09900 CMHC			0	0	0	99.00
99.10 09910 CORF			0	0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM			0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY			0	0	0	101.00
102.00 10200 OPIOID TREATMENT PROGRAM			0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION			0	0	0	105.00
106.00 10600 HEART ACQUISITION			0	0	0	106.00
107.00 10700 LIVER ACQUISITION			0	0	0	107.00
108.00 10800 LUNG ACQUISITION			0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION			0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION			0	0	0	110.00
111.00 11100 ISLET ACQUISITION			0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)			0	0	0	115.00
116.00 11600 HOSPICE			0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	3,566,081	0	3,566,081	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN			5,416	0	5,416	190.00
191.00 19100 RESEARCH			0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES			33,698	0	33,698	192.00
193.00 19300 NONPAID WORKERS			0	0	0	193.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS			0	0	0	194.00
194.01 07951 PAIN CLINIC			0	0	0	194.01
194.02 07952 OCC HEALTH			0	0	0	194.02
194.03 07953 FOUNDATION			362	0	362	194.03
194.04 07954 PHYSICIAN OFFICES			0	0	0	194.04
194.05 07955 COMMUNITY & VOLUNTEER SERVICES			37,612	0	37,612	194.05
194.06 07956 VACANT SPACE			0	0	0	194.06
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	0	3,643,169	0	3,643,169	202.00



COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0146

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

Worksheet B-1

Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	137,798				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		908,828			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	26,383,156		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	29,785	10,266	9,179,902	-18,548,550	35,325,458
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	11,508	20,530	467,407	0	1,316,925
8.00 00800	LAUNDRY & LINEN SERVICE	990	0	0	0	166,059
9.00 00900	HOUSEKEEPING	1,432	2,860	499,081	0	724,861
10.00 01000	DIETARY	3,164	7,767	310,214	0	541,856
11.00 01100	CAFETERIA	1,907	0	215,060	0	155,332
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	401	78	581,752	0	726,203
14.00 01400	CENTRAL SERVICES & SUPPLY	3,683	0	0	0	9,155
15.00 01500	PHARMACY	1,086	2,607	776,684	0	191,425
16.00 01600	MEDICAL RECORDS & LIBRARY	1,659	0	0	0	4,124
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING PROGRAM	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	17,322	73,304	2,553,713	0	3,848,186
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0
43.00 04300	NURSERY	249	5,627	159,466	0	270,924
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00 04500	NURSING FACILITY	0	0	0	0	0
46.00 04600	OTHER LONG TERM CARE	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	18,122	120,940	1,214,115	0	2,480,451
51.00 05100	RECOVERY ROOM	0	0	0	0	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,599	22,708	643,567	0	1,094,862
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	8,759	276,979	1,457,223	0	3,146,379
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00 05600	RADIOISOTOPE	0	0	0	0	0
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	3,347	0	0	0	3,026,762
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	2,135	67,856	827,672	0	1,298,053
66.00 06600	PHYSICAL THERAPY	9,229	6,959	677,668	0	889,985
67.00 06700	OCCUPATIONAL THERAPY	0	0	473,283	0	602,318
68.00 06800	SPEECH PATHOLOGY	0	0	194,582	0	247,632
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	431,246
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	557,010
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,134,808
74.00 07400	RENAL DIALYSIS	0	0	0	0	0
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY	1,700	10,230	357,778	0	576,464
77.00 07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00 09000	CLINIC	0	0	50,513	0	66,855
91.00 09100	EMERGENCY	7,254	27,556	1,702,034	0	2,573,927

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0146

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

Worksheet B-1

Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 09500 AMBULANCE SERVICES	0	251,747	3,858,291	0	5,930,865	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
99.00 09900 CMHC	0	0	0	0	0	99.00
99.10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 11600 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	125,331	908,014	26,200,005	-18,548,550	35,012,667	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,011	63	0	0	11,856	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	6,515	155	37,998	0	64,919	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 07951 PAIN CLINIC	0	0	0	0	0	194.01
194.02 07952 OCC HEALTH	0	0	0	0	0	194.02
194.03 07953 FOUNDATION	0	0	0	0	5,800	194.03
194.04 07954 PHYSICIAN OFFICES	0	0	0	0	0	194.04
194.05 07955 COMMUNITY & VOLUNTEER SERVICES	4,941	596	145,153	0	230,216	194.05
194.06 07956 VACANT SPACE	0	0	0	0	0	194.06
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)	342,536	1,184,355	6,295,427		18,548,550	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	2.485784	1.303167	0.238615		0.525076	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			0		2,203,695	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000000		0.062383	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0146

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

Worksheet B-1

Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
<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
6.00	00600	108,013					6.00
7.00	00700	11,508	96,505				7.00
8.00	00800	990	990	258,763			8.00
9.00	00900	1,432	1,432	0	94,083		9.00
10.00	01000	3,164	3,164	0	3,164	24,190	10.00
11.00	01100	1,907	1,907	0	1,907	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	401	401	0	401	0	13.00
14.00	01400	3,683	3,683	7,894	3,683	0	14.00
15.00	01500	1,086	1,086	0	1,086	0	15.00
16.00	01600	1,659	1,659	0	1,659	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	17,322	17,322	100,331	17,322	24,190	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
43.00	04300	249	249	1,619	249	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	18,122	18,122	56,511	18,122	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	1,599	1,599	1,620	1,599	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	8,759	8,759	25,993	8,759	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	3,347	3,347	0	3,347	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	2,135	2,135	1,592	2,135	0	65.00
66.00	06600	9,229	9,229	0	9,229	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
76.98	07698	1,700	1,700	374	1,700	0	76.98
77.00	07700	0	0	0	0	0	77.00
78.00	07800	0	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	7,254	7,254	60,881	7,254	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	0	0	0	0	0	94.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0146

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

Worksheet B-1

Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	95,546	84,038	256,815	81,616	24,190	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,011	1,011	0	1,011	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,515	6,515	1,948	6,515	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	4,941	4,941	0	4,941	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
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)	0	2,008,411	273,856	1,135,270	930,398	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	20.811471	1.058328	12.066686	38.462092	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	137,514	14,231	54,547	58,133	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	1.424942	0.054996	0.579775	2.403183	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0146

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

Worksheet B-1

Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description			CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATIVE (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
<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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	408,562					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	10,173	0	167,337			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	2,830,943		14.00
15.00	01500	PHARMACY	11,708	0	0	36,455	4,072,029	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	66,107	0	66,107	345,665	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - I/PF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I/RF	0	0	0	0	0	41.00
43.00	04300	NURSERY	4,065	0	4,065	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	28,068	0	28,068	456,637	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,407	0	16,407	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,978	0	0	94,585	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	21,485	0	0	96,311	0	65.00
66.00	06600	PHYSICAL THERAPY	14,353	0	0	16,867	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,742	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,828	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	988,256	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	62,779	4,072,029	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.98	07698	HYPERBARIIC OXYGEN THERAPY	11,098	0	11,098	105,215	0	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,160	0	0	4,287	0	90.00
91.00	09100	EMERGENCY	41,592	0	41,592	314,792	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0146

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

Worksheet B-1

Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description		CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500 AMBULANCE SERVICES	119,728	0	0	298,777	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
99.00	09900 CMHC	0	0	0	0	0	99.00
99.10	09910 CORF	0	0	0	0	0	99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
105.00	10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF						114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600 HOSPICE	0	0	0	0	0	116.00
118.00	11800 SUBTOTALS (SUM OF LINES 1 through 117)	400,492	0	167,337	2,820,626	4,072,029	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	8,747	0	190.00
191.00	19100 RESEARCH	0	0	0	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	1,729	0	0	1,191	0	192.00
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951 PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952 OCC HEALTH	0	0	0	0	0	194.02
194.03	07953 FOUNDATION	0	0	0	0	0	194.03
194.04	07954 PHYSICIAN OFFICES	0	0	0	0	0	194.04
194.05	07955 COMMUNITY & VOLUNTEER SERVICES	6,341	0	0	379	0	194.05
194.06	07956 VACANT SPACE	0	0	0	0	0	194.06
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)	299,591	0	1,128,159	143,407	338,075	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.733282	0.000000	6.741838	0.050657	0.083024	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	18,253	0	47,659	17,543	20,965	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.044676	0.000000	0.284809	0.006197	0.005149	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0146

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

Worksheet B-1

Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	
	16.00	17.00	19.00	20.00	21.00		
<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
6.00 00600 MAINTENANCE & REPAIRS							6.00
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
12.00 01200 MAINTENANCE OF PERSONNEL							12.00
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	275,834,211						16.00
17.00 01700 SOCIAL SERVICE	0	0					17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0				19.00
20.00 02000 NURSING PROGRAM	0	0		0			20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0			0		21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0					22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	16,949,385	0	0	0	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00
32.00 03200 CORONARY CARE UNIT	0	0	0	0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	0	34.00
40.00 04000 SUBPROVIDER - IPF	0	0	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	0	41.00
43.00 04300 NURSERY	885,873	0	0	0	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00
45.00 04500 NURSING FACILITY	0	0	0	0	0	0	45.00
46.00 04600 OTHER LONG TERM CARE	0	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	28,405,516	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3,575,171	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	44,971,387	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 06000 LABORATORY	41,061,216	0	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	14,706,974	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	4,908,284	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	1,587,598	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1,129,293	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,987,575	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3,270,355	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	26,931,790	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
76.98 07698 HYPERBARIC OXYGEN THERAPY	5,011,095	0	0	0	0	0	76.98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00 09000 CLINIC	265,804	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	55,092,034	0	0	0	0	0	91.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0146

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

Worksheet B-1

Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS	92.00
	16.00	17.00	19.00	20.00	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 09500 AMBULANCE SERVICES	24,094,861	0	0	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
99.00 09900 CMHC	0	0	0	0	0	99.00
99.10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 11600 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	275,834,211	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 07951 PAIN CLINIC	0	0	0	0	0	194.01
194.02 07952 OCC HEALTH	0	0	0	0	0	194.02
194.03 07953 FOUNDATION	0	0	0	0	0	194.03
194.04 07954 PHYSICIAN OFFICES	0	0	0	0	0	194.04
194.05 07955 COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.05
194.06 07956 VACANT SPACE	0	0	0	0	0	194.06
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)	60,834	0	0	0	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.000221	0.000000	0.000000	0.000000	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	7,707	0	0	0	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000028	0.000000	0.000000	0.000000	0.000000	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00



COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0146

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

Worksheet B-1  
Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description		INTERNS & RESIDENTS	
		SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	
		22.00	
<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
6.00	00600	MAINTENANCE & REPAIRS	6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING PROGRAM	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
32.00	03200	CORONARY CARE UNIT	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	34.00
40.00	04000	SUBPROVIDER - I PF	40.00
41.00	04100	SUBPROVIDER - I RF	41.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
45.00	04500	NURSING FACILITY	45.00
46.00	04600	OTHER LONG TERM CARE	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
64.00	06400	INTRAVENOUS THERAPY	64.00
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
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800	RURAL HEALTH CLINIC	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0146

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

Worksheet B-1

Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description		INTERNS & RESIDENTS		
		SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)		
		22.00		
<b>OTHER REIMBURSABLE COST CENTERS</b>				
94.00	09400 HOME PROGRAM DIALYSIS	0		94.00
95.00	09500 AMBULANCE SERVICES	0		95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0		96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0		97.00
99.00	09900 CMHC	0		99.00
99.10	09910 CORF	0		99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0		100.00
101.00	10100 HOME HEALTH AGENCY	0		101.00
102.00	10200 OPIOID TREATMENT PROGRAM	0		102.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
105.00	10500 KIDNEY ACQUISITION	0		105.00
106.00	10600 HEART ACQUISITION	0		106.00
107.00	10700 LIVER ACQUISITION	0		107.00
108.00	10800 LUNG ACQUISITION	0		108.00
109.00	10900 PANCREAS ACQUISITION	0		109.00
110.00	11000 INTESTINAL ACQUISITION	0		110.00
111.00	11100 ISLET ACQUISITION	0		111.00
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW-SNF			114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0		115.00
116.00	11600 HOSPICE			116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0		118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100 RESEARCH	0		191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0		192.00
193.00	19300 NONPAID WORKERS	0		193.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0		194.00
194.01	07951 PAIN CLINIC	0		194.01
194.02	07952 OCC HEALTH	0		194.02
194.03	07953 FOUNDATION	0		194.03
194.04	07954 PHYSICIAN OFFICES	0		194.04
194.05	07955 COMMUNITY & VOLUNTEER SERVICES	0		194.05
194.06	07956 VACANT SPACE	0		194.06
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)	0		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0146

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/23/2024 9:53 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	7,990,286		7,990,286	0	7,990,286	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0		0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
43.00	04300	NURSERY	453,663		453,663	0	453,663	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	4,677,727		4,677,727	0	4,677,727	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,847,469		1,847,469	0	1,847,469	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,156,535		5,156,535	0	5,156,535	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	4,735,160		4,735,160	0	4,735,160	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,075,392	0	2,075,392	0	2,075,392	65.00
66.00	06600	PHYSICAL THERAPY	1,673,191	0	1,673,191	0	1,673,191	66.00
67.00	06700	OCCUPATIONAL THERAPY	927,542	0	927,542	0	927,542	67.00
68.00	06800	SPEECH PATHOLOGY	381,448	0	381,448	0	381,448	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	708,407		708,407	0	708,407	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	850,206		850,206	0	850,206	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,653,103		6,653,103	0	6,653,103	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,024,836		1,024,836	0	1,024,836	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	103,086		103,086	0	103,086	90.00
91.00	09100	EMERGENCY	4,567,264		4,567,264	32,679	4,599,943	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,726,433		2,726,433	0	2,726,433	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	9,153,272		9,153,272	0	9,153,272	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
99.00	09900	CMHC	0		0	0	0	99.00
99.10	09910	CORF	0		0	0	0	99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0		0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
105.00	10500	KIDNEY ACQUISITION	0		0	0	0	105.00
106.00	10600	HEART ACQUISITION	0		0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0		0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0		0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0		0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0		0	0	0	114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D. P.)	0		0	0	0	115.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0146

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col . 26)	Therapy Limit Adj .	Costs			
				Total Costs	RCE	Total Costs	
					Disallowance		
1.00	2.00	3.00	4.00	5.00			
116.00	11600	HOSPICE	0	0	0	0	116.00
200.00		Subtotal (see instructions)	55,705,020	0	55,705,020	32,679	55,737,699
201.00		Less Observation Beds	2,726,433		2,726,433		2,726,433
202.00		Total (see instructions)	52,978,587	0	52,978,587	32,679	53,011,266

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0146		Period: From 01/01/2023 To 12/31/2023		Worksheet C Part I Date/Time Prepared: 5/23/2024 9:53 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		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	14,346,283		14,346,283				30.00
31.00	03100	INTENSIVE CARE UNIT	0		0				31.00
32.00	03200	CORONARY CARE UNIT	0		0				32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0				33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0				34.00
40.00	04000	SUBPROVIDER - I PF	0		0				40.00
41.00	04100	SUBPROVIDER - I RF	0		0				41.00
43.00	04300	NURSERY	885,873		885,873				43.00
44.00	04400	SKILLED NURSING FACILITY	0		0				44.00
45.00	04500	NURSING FACILITY	0		0				45.00
46.00	04600	OTHER LONG TERM CARE	0		0				46.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	7,052,992	21,352,524	28,405,516	0.164677	0.000000		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,575,171	0	3,575,171	0.516750	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,966,238	40,005,149	44,971,387	0.114663	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000		55.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000		56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000		59.00
60.00	06000	LABORATORY	7,854,999	33,206,217	41,061,216	0.115320	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	3,238,185	11,468,789	14,706,974	0.141116	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	206,957	4,701,327	4,908,284	0.340891	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	122,499	1,465,099	1,587,598	0.584242	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	95,781	1,033,512	1,129,293	0.337776	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	463,018	2,524,557	2,987,575	0.237118	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	282,649	2,987,706	3,270,355	0.259974	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,415,378	21,516,412	26,931,790	0.247035	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000		75.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	44,333	4,966,762	5,011,095	0.204513	0.000000		76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000		78.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0				89.00
90.00	09000	CLINIC	5,959	259,845	265,804	0.387827	0.000000		90.00
91.00	09100	EMERGENCY	7,353,469	47,738,565	55,092,034	0.082902	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	214,430	2,388,672	2,603,102	1.047378	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000		94.00
95.00	09500	AMBULANCE SERVICES	0	24,094,861	24,094,861	0.379885	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000		97.00
99.00	09900	CMHC	0	0	0				99.00
99.10	09910	CORF	0	0	0				99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0				100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0				101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0				102.00
SPECIAL PURPOSE COST CENTERS									
105.00	10500	KIDNEY ACQUISITION	0	0	0				105.00
106.00	10600	HEART ACQUISITION	0	0	0				106.00
107.00	10700	LIVER ACQUISITION	0	0	0				107.00
108.00	10800	LUNG ACQUISITION	0	0	0				108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0				109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0				110.00
111.00	11100	ISLET ACQUISITION	0	0	0				111.00
113.00	11300	INTEREST EXPENSE	0	0	0				113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0				114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0				115.00
116.00	11600	HOSPICE	0	0	0				116.00

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col . 6 + col . 7)			
200.00	Subtotal (see instructions)	56,124,214	219,709,997	275,834,211			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	56,124,214	219,709,997	275,834,211			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/23/2024 9:53 am
Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital PPS
			11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
32.00	03200	CORONARY CARE UNIT			32.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
46.00	04600	OTHER LONG TERM CARE			46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.164677		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.516750		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.114663		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.115320		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.141116		65.00
66.00	06600	PHYSICAL THERAPY	0.340891		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.584242		67.00
68.00	06800	SPEECH PATHOLOGY	0.337776		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.237118		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.259974		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247035		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.204513		76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.387827		90.00
91.00	09100	EMERGENCY	0.083496		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.047378		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		94.00
95.00	09500	AMBULANCE SERVICES	0.379885		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
99.00	09900	CMHC			99.00
99.10	09910	CORF			99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	10100	HOME HEALTH AGENCY			101.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
105.00	10500	KIDNEY ACQUISITION			105.00
106.00	10600	HEART ACQUISITION			106.00
107.00	10700	LIVER ACQUISITION			107.00
108.00	10800	LUNG ACQUISITION			108.00
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/23/2024 9:53 am
		Title XVIII	Hospital	PPS
Cost Center Description		PPS Inpatient Ratio		
		11.00		
202.00	Total (see instructions)			202.00



COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/23/2024 9:53 am		
		Title XIX	Hospital	PPS		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	7,990,286			30.00
31.00	03100	INTENSIVE CARE UNIT	0			31.00
32.00	03200	CORONARY CARE UNIT	0			32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0			34.00
40.00	04000	SUBPROVIDER - IPF	0			40.00
41.00	04100	SUBPROVIDER - IRF	0			41.00
43.00	04300	NURSERY	453,663			43.00
44.00	04400	SKILLED NURSING FACILITY	0			44.00
45.00	04500	NURSING FACILITY	0			45.00
46.00	04600	OTHER LONG TERM CARE	0			46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	4,677,727			50.00
51.00	05100	RECOVERY ROOM	0			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,847,469			52.00
53.00	05300	ANESTHESIOLOGY	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,156,535			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0			55.00
56.00	05600	RADIOISOTOPE	0			56.00
57.00	05700	CT SCAN	0			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0			59.00
60.00	06000	LABORATORY	4,735,160			60.00
60.01	06001	BLOOD LABORATORY	0			60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0			61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0			62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0			63.00
64.00	06400	INTRAVENOUS THERAPY	0			64.00
65.00	06500	RESPIRATORY THERAPY	2,075,392	0		65.00
66.00	06600	PHYSICAL THERAPY	1,673,191	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	927,542	0		67.00
68.00	06800	SPEECH PATHOLOGY	381,448	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	708,407			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	850,206			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,653,103			73.00
74.00	07400	RENAL DIALYSIS	0			74.00
75.00	07500	ASC (NON-DISTINCT PART)	0			75.00
76.98	07698	HYPERBARIIC OXYGEN THERAPY	1,024,836			76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0			77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0			78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0			89.00
90.00	09000	CLINIC	103,086			90.00
91.00	09100	EMERGENCY	4,567,264		32,679	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,726,433			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00	09400	HOME PROGRAM DIALYSIS	0			94.00
95.00	09500	AMBULANCE SERVICES	9,153,272			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0			96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0			97.00
99.00	09900	CMHC	0			99.00
99.10	09910	CORF	0			99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0			100.00
101.00	10100	HOME HEALTH AGENCY	0			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0			102.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
105.00	10500	KIDNEY ACQUISITION	0			105.00
106.00	10600	HEART ACQUISITION	0			106.00
107.00	10700	LIVER ACQUISITION	0			107.00
108.00	10800	LUNG ACQUISITION	0			108.00
109.00	10900	PANCREAS ACQUISITION	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0			110.00
111.00	11100	ISLET ACQUISITION	0			111.00
113.00	11300	INTEREST EXPENSE	0			113.00
114.00	11400	UTILIZATION REVIEW-SNF	0			114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D. P.)	0			115.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0146

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col . 26)	Therapy Limit Adj .	Costs			
				Total Costs	RCE	Total Costs	
					Disallowance		
1.00	2.00	3.00	4.00	5.00			
116.00	11600	HOSPICE	0	0	0	0	116.00
200.00		Subtotal (see instructions)	55,705,020	0	55,705,020	32,679	55,737,699
201.00		Less Observation Beds	2,726,433		2,726,433		2,726,433
202.00		Total (see instructions)	52,978,587	0	52,978,587	32,679	53,011,266

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/23/2024 9:53 am		
				Title XIX	Hospital	PPS		
Cost Center Description				Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
				Inpatient	Outpatient	Total (col. 6 + col. 7)		
				6.00	7.00	8.00	9.00	10.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	14,346,283		14,346,283			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
32.00	03200	CORONARY CARE UNIT	0		0			32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0			34.00
40.00	04000	SUBPROVIDER - I/PF	0		0			40.00
41.00	04100	SUBPROVIDER - I/RF	0		0			41.00
43.00	04300	NURSERY	885,873		885,873			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	7,052,992	21,352,524	28,405,516	0.164677	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,575,171	0	3,575,171	0.516750	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,966,238	40,005,149	44,971,387	0.114663	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	7,854,999	33,206,217	41,061,216	0.115320	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,238,185	11,468,789	14,706,974	0.141116	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	206,957	4,701,327	4,908,284	0.340891	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	122,499	1,465,099	1,587,598	0.584242	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	95,781	1,033,512	1,129,293	0.337776	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	463,018	2,524,557	2,987,575	0.237118	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	282,649	2,987,706	3,270,355	0.259974	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,415,378	21,516,412	26,931,790	0.247035	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	44,333	4,966,762	5,011,095	0.204513	0.000000	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	5,959	259,845	265,804	0.387827	0.000000	90.00
91.00	09100	EMERGENCY	7,353,469	47,738,565	55,092,034	0.082902	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	214,430	2,388,672	2,603,102	1.047378	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000	94.00
95.00	09500	AMBULANCE SERVICES	0	24,094,861	24,094,861	0.379885	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
99.00	09900	CMHC	0	0	0	0.000000	0.000000	99.00
99.10	09910	CORF	0	0	0	0.000000	0.000000	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0.000000	0.000000	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0.000000	0.000000	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0.000000	0.000000	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0.000000	0.000000	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0.000000	0.000000	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0.000000	0.000000	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0.000000	0.000000	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0.000000	0.000000	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0.000000	0.000000	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0.000000	0.000000	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0.000000	0.000000	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0.000000	0.000000	114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0.000000	0.000000	115.00
116.00	11600	HOSPICE	0	0	0	0.000000	0.000000	116.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0146			Period: From 01/01/2023 To 12/31/2023		Worksheet C Part I Date/Time Prepared: 5/23/2024 9:53 am	
		Title XIX			Hospital		PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col . 6 + col . 7)				
		6.00	7.00	8.00	9.00	10.00		
200.00	Subtotal (see instructions)	56,124,214	219,709,997	275,834,211			200.00	
201.00	Less Observation Beds						201.00	
202.00	Total (see instructions)	56,124,214	219,709,997	275,834,211			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/23/2024 9:53 am
Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital
			11.00		PPS
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
32.00	03200	CORONARY CARE UNIT			32.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
46.00	04600	OTHER LONG TERM CARE			46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.164677		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.516750		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.114663		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.115320		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.141116		65.00
66.00	06600	PHYSICAL THERAPY	0.340891		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.584242		67.00
68.00	06800	SPEECH PATHOLOGY	0.337776		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.237118		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.259974		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247035		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.204513		76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.387827		90.00
91.00	09100	EMERGENCY	0.083496		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.047378		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		94.00
95.00	09500	AMBULANCE SERVICES	0.379885		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
99.00	09900	CMHC			99.00
99.10	09910	CORF			99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	10100	HOME HEALTH AGENCY			101.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
105.00	10500	KIDNEY ACQUISITION	0.000000		105.00
106.00	10600	HEART ACQUISITION	0.000000		106.00
107.00	10700	LIVER ACQUISITION	0.000000		107.00
108.00	10800	LUNG ACQUISITION	0.000000		108.00
109.00	10900	PANCREAS ACQUISITION	0.000000		109.00
110.00	11000	INTESTINAL ACQUISITION	0.000000		110.00
111.00	11100	ISLET ACQUISITION	0.000000		111.00
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/23/2024 9:53 am
		Title XIX	Hospital	PPS
Cost Center Description	PPS Inpatient Ratio			
202.00	11.00			
Total (see instructions)				
202.00				

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 15-0146		Period: From 01/01/2023 To 12/31/2023		Worksheet C Part II Date/Time Prepared: 5/23/2024 9:53 am	
Cost Center Description		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	PPS
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	4,677,727	409,700	4,268,027	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,847,469	110,668	1,736,801	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,156,535	601,536	4,554,999	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	4,735,160	204,998	4,530,162	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	2,075,392	181,048	1,894,344	0	0	65.00
66.00	06600 PHYSICAL THERAPY	1,673,191	106,915	1,566,276	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	927,542	38,143	889,399	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	381,448	15,696	365,752	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	708,407	33,109	675,298	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	850,206	34,840	815,366	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6,653,103	280,050	6,373,053	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.98	07698 HYPERBARIC OXYGEN THERAPY	1,024,836	61,397	963,439	0	0	76.98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	103,086	4,257	98,829	0	0	90.00
91.00	09100 EMERGENCY	4,567,264	249,583	4,317,681	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,726,433	171,095	2,555,338	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500 AMBULANCE SERVICES	9,153,272	705,915	8,447,357	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
99.00	09900 CMHC	0	0	0	0	0	99.00
99.10	09910 CORF	0	0	0	0	0	99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
105.00	10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	11400 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600 HOSPICE	0	0	0	0	0	116.00
200.00	Subtotal (sum of lines 50 thru 199)	47,261,071	3,208,950	44,052,121	0	0	200.00
201.00	Less Observation Beds	2,726,433	171,095	2,555,338	0	0	201.00
202.00	Total (line 200 minus line 201)	44,534,638	3,037,855	41,496,783	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 15-0146		Period: From 01/01/2023 To 12/31/2023		Worksheet C Part II Date/Time Prepared: 5/23/2024 9:53 am	
Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS	
		6.00	7.00	8.00			
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	4,677,727	28,405,516	0.164677			50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,847,469	3,575,171	0.516750			52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,156,535	44,971,387	0.114663			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000			55.00
56.00	05600 RADIOISOTOPE	0	0	0.000000			56.00
57.00	05700 CT SCAN	0	0	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000			59.00
60.00	06000 LABORATORY	4,735,160	41,061,216	0.115320			60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000			60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000			61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000			62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000			63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	2,075,392	14,706,974	0.141116			65.00
66.00	06600 PHYSICAL THERAPY	1,673,191	4,908,284	0.340891			66.00
67.00	06700 OCCUPATIONAL THERAPY	927,542	1,587,598	0.584242			67.00
68.00	06800 SPEECH PATHOLOGY	381,448	1,129,293	0.337776			68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	708,407	2,987,575	0.237118			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	850,206	3,270,355	0.259974			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6,653,103	26,931,790	0.247035			73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000			74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000			75.00
76.98	07698 HYPERBARIC OXYGEN THERAPY	1,024,836	5,011,095	0.204513			76.98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000			77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.000000			78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000			89.00
90.00	09000 CLINIC	103,086	265,804	0.387827			90.00
91.00	09100 EMERGENCY	4,567,264	55,092,034	0.082902			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,726,433	2,603,102	1.047378			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000			94.00
95.00	09500 AMBULANCE SERVICES	9,153,272	24,094,861	0.379885			95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000			96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000			97.00
99.00	09900 CMHC	0	0	0.000000			99.00
99.10	09910 CORF	0	0	0.000000			99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0.000000			100.00
101.00	10100 HOME HEALTH AGENCY	0	0	0.000000			101.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0.000000			102.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
105.00	10500 KIDNEY ACQUISITION	0	0	0.000000			105.00
106.00	10600 HEART ACQUISITION	0	0	0.000000			106.00
107.00	10700 LIVER ACQUISITION	0	0	0.000000			107.00
108.00	10800 LUNG ACQUISITION	0	0	0.000000			108.00
109.00	10900 PANCREAS ACQUISITION	0	0	0.000000			109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0.000000			110.00
111.00	11100 ISLET ACQUISITION	0	0	0.000000			111.00
113.00	11300 INTEREST EXPENSE	0	0	0.000000			113.00
114.00	11400 UTILIZATION REVIEW-SNF	0	0	0.000000			114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0.000000			115.00
116.00	11600 HOSPICE	0	0	0.000000			116.00
200.00	Subtotal (sum of lines 50 thru 199)	47,261,071	260,602,055				200.00
201.00	Less Observation Beds	2,726,433	0				201.00
202.00	Total (line 200 minus line 201)	44,534,638	260,602,055				202.00



APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Prepared: 5/23/2024 9:53 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	501,420	0	501,420	6,975	71.89	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
32.00	CORONARY CARE UNIT	0		0	0	0.00	32.00
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00	NURSERY	26,806		26,806	462	58.02	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30 through 199)	528,226		528,226	7,437		200.00

Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
INPATIENT ROUTINE SERVICE COST CENTERS				

30.00	ADULTS & PEDIATRICS	1,016	73,040	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
32.00	CORONARY CARE UNIT	0	0	32.00
33.00	BURN INTENSIVE CARE UNIT	0	0	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
40.00	SUBPROVIDER - IPF	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
45.00	NURSING FACILITY	0	0	45.00
200.00	Total (lines 30 through 199)	1,016	73,040	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prepared: 5/23/2024 9:53 am		
				Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. C, 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	409,700	28,405,516	0.014423	634,106	9,146	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	110,668	3,575,171	0.030955	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	601,536	44,971,387	0.013376	1,529,775	20,462	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	204,998	41,061,216	0.004992	1,749,810	8,735	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	181,048	14,706,974	0.012310	522,193	6,428	65.00
66.00	06600	PHYSICAL THERAPY	106,915	4,908,284	0.021783	62,012	1,351	66.00
67.00	06700	OCCUPATIONAL THERAPY	38,143	1,587,598	0.024026	31,143	748	67.00
68.00	06800	SPEECH PATHOLOGY	15,696	1,129,293	0.013899	31,507	438	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,109	2,987,575	0.011082	101,021	1,120	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,840	3,270,355	0.010653	95,432	1,017	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	280,050	26,931,790	0.010398	1,049,608	10,914	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	61,397	5,011,095	0.012252	24,174	296	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	4,257	265,804	0.016016	0	0	90.00
91.00	09100	EMERGENCY	249,583	55,092,034	0.004530	1,842,255	8,345	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	171,095	2,603,102	0.065727	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50 through 199)	2,503,035	236,507,194		7,673,036	69,000	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Prepared: 5/23/2024 9:53 am
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Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS			1A	1.00	2A	2.00	3.00		
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00	
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00	
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 col. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
INPATIENT ROUTINE SERVICE COST CENTERS			4.00	5.00	6.00	7.00	8.00		
30.00	03000	ADULTS & PEDIATRICS	0	0	6,975	0.00	1,016	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0.00	0	31.00	
32.00	03200	CORONARY CARE UNIT	0	0	0	0.00	0	32.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0.00	0	33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0.00	0	34.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00	
43.00	04300	NURSERY	0	0	462	0.00	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0	44.00	
45.00	04500	NURSING FACILITY	0	0	0	0.00	0	45.00	
200.00		Total (lines 30 through 199)	0	0	7,437	0.00	1,016	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
INPATIENT ROUTINE SERVICE COST CENTERS			9.00						
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
32.00	03200	CORONARY CARE UNIT	0						32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0						33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0						34.00
40.00	04000	SUBPROVIDER - IPF	0						40.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
43.00	04300	NURSERY	0						43.00
44.00	04400	SKILLED NURSING FACILITY	0						44.00
45.00	04500	NURSING FACILITY	0						45.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/23/2024 9:53 am
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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		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/23/2024 9:53 am
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	PPS	
					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	28,405,516	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	3,575,171	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	44,971,387	0.000000	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00 05700 CT SCAN	0	0	0	0	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	41,061,216	0.000000	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0.000000	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0.000000	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	14,706,974	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	4,908,284	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	1,587,598	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	1,129,293	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,987,575	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,270,355	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	26,931,790	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	5,011,095	0.000000	76.98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00 09000 CLINIC	0	0	0	265,804	0.000000	90.00
91.00 09100 EMERGENCY	0	0	0	55,092,034	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,603,102	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
95.00 09500 AMBULANCE SERVICES						95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0.000000	97.00
200.00 Total (lines 50 through 199)	0	0	0	236,507,194		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/23/2024 9:53 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	634,106	0	2,081,185	0	50.00	
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	1,529,775	0	5,724,376	0	54.00	
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00	
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00	
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00	06000 LABORATORY	0.000000	1,749,810	0	1,999,206	0	60.00	
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0	61.00	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00	
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00	
65.00	06500 RESPIRATORY THERAPY	0.000000	522,193	0	1,364,060	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	62,012	0	21,952	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	31,143	0	13,163	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	31,507	0	3,957	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	101,021	0	190,329	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	95,432	0	556,668	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	1,049,608	0	9,167,359	0	73.00	
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00	
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00	
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	24,174	0	1,271,386	0	76.98	
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00	
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00	
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00	
91.00	09100 EMERGENCY	0.000000	1,842,255	0	4,718,022	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	186,575	0	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00	
95.00	09500 AMBULANCE SERVICES	0.000000	0	0	0	0	95.00	
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00	
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00	
200.00	Total (lines 50 through 199)		7,673,036	0	27,298,238	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/23/2024 9:53 am
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Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.164677	2,081,185	0	0	342,723	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.516750	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.114663	5,724,376	0	0	656,374	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.115320	1,999,206	0	0	230,548	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.141116	1,364,060	0	0	192,491	65.00
66.00	06600	PHYSICAL THERAPY	0.340891	21,952	0	0	7,483	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.584242	13,163	0	0	7,690	67.00
68.00	06800	SPEECH PATHOLOGY	0.337776	3,957	0	0	1,337	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.237118	190,329	0	0	45,130	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.259974	556,668	0	0	144,719	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247035	9,167,359	0	0	2,264,659	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.204513	1,271,386	0	0	260,015	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC						88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	0.387827	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.082902	4,718,022	0	0	391,133	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.047378	186,575	0	0	195,415	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		0	0		94.00
95.00	09500	AMBULANCE SERVICES	0.379885		0	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Subtotal (see instructions)		27,298,238	0	0	4,739,717	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		27,298,238	0	0	4,739,717	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/23/2024 9:53 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800 RURAL HEALTH CLINIC				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94.00
95.00 09500 AMBULANCE SERVICES	0	0		95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0		201.00
202.00 Net Charges (line 200 - line 201)	0	0		202.00



APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Prepared: 5/23/2024 9:53 am
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Cost Center Description	Title XIX			Hospital	PPS	
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	501,420	0	501,420	6,975	71.89	30.00
31.00 INTENSIVE CARE UNIT	0		0	0	0.00	31.00
32.00 CORONARY CARE UNIT	0		0	0	0.00	32.00
33.00 BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
40.00 SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00 NURSERY	26,806		26,806	462	58.02	43.00
44.00 SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00 NURSING FACILITY	0		0	0	0.00	45.00
200.00 Total (lines 30 through 199)	528,226		528,226	7,437		200.00

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	6.00	7.00	

INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	123	8,842				30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
32.00 CORONARY CARE UNIT	0	0				32.00
33.00 BURN INTENSIVE CARE UNIT	0	0				33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0				34.00
40.00 SUBPROVIDER - IPF	0	0				40.00
41.00 SUBPROVIDER - IRF	0	0				41.00
43.00 NURSERY	40	2,321				43.00
44.00 SKILLED NURSING FACILITY	0	0				44.00
45.00 NURSING FACILITY	0	0				45.00
200.00 Total (lines 30 through 199)	163	11,163				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prepared: 5/23/2024 9:53 am
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Cost Center Description		Title XIX			Hospital	PPS	
		Capital Related Cost (from Wkst. C, 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	409,700	28,405,516	0.014423	337,143	4,863	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	110,668	3,575,171	0.030955	80,033	2,477	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	601,536	44,971,387	0.013376	88,322	1,181	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	204,998	41,061,216	0.004992	250,376	1,250	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	181,048	14,706,974	0.012310	58,707	723	65.00
66.00	06600 PHYSICAL THERAPY	106,915	4,908,284	0.021783	1,840	40	66.00
67.00	06700 OCCUPATIONAL THERAPY	38,143	1,587,598	0.024026	1,134	27	67.00
68.00	06800 SPEECH PATHOLOGY	15,696	1,129,293	0.013899	2,031	28	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	33,109	2,987,575	0.011082	22,188	246	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	34,840	3,270,355	0.010653	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	280,050	26,931,790	0.010398	147,089	1,529	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.98	07698 HYPERBARIC OXYGEN THERAPY	61,397	5,011,095	0.012252	5,359	66	76.98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	4,257	265,804	0.016016	0	0	90.00
91.00	09100 EMERGENCY	249,583	55,092,034	0.004530	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	171,095	2,603,102	0.065727	151,460	9,955	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00	Total (lines 50 through 199)	2,503,035	236,507,194		1,145,682	22,385	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Prepared: 5/23/2024 9:53 am
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Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS			1A	1.00	2A	2.00	3.00		
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00	
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00	
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 col. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
INPATIENT ROUTINE SERVICE COST CENTERS			4.00	5.00	6.00	7.00	8.00		
30.00	03000	ADULTS & PEDIATRICS	0	0	6,975	0.00	123	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0.00	0	31.00	
32.00	03200	CORONARY CARE UNIT	0	0	0	0.00	0	32.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0.00	0	33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0.00	0	34.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00	
43.00	04300	NURSERY	0	0	462	0.00	40	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0	44.00	
45.00	04500	NURSING FACILITY	0	0	0	0.00	0	45.00	
200.00		Total (lines 30 through 199)	0	0	7,437	0.00	163	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
INPATIENT ROUTINE SERVICE COST CENTERS			9.00						
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
32.00	03200	CORONARY CARE UNIT	0						32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0						33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0						34.00
40.00	04000	SUBPROVIDER - IPF	0						40.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
43.00	04300	NURSERY	0						43.00
44.00	04400	SKILLED NURSING FACILITY	0						44.00
45.00	04500	NURSING FACILITY	0						45.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/23/2024 9:53 am
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Cost Center Description	Title XIX			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		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/23/2024 9:53 am
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Cost Center Description	Title XIX			Hospital	PPS	
	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
	4.00	5.00	6.00	7.00	8.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	28,405,516	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	3,575,171	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	44,971,387	0.000000	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00 05700 CT SCAN	0	0	0	0	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	41,061,216	0.000000	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0.000000	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0.000000	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	14,706,974	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	4,908,284	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	1,587,598	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	1,129,293	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,987,575	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,270,355	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	26,931,790	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	5,011,095	0.000000	76.98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00 09000 CLINIC	0	0	0	265,804	0.000000	90.00
91.00 09100 EMERGENCY	0	0	0	55,092,034	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,603,102	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
95.00 09500 AMBULANCE SERVICES						95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0.000000	97.00
200.00 Total (lines 50 through 199)	0	0	0	236,507,194		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/23/2024 9:53 am
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Cost Center Description		Title XIX				Hospital	
		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)	PPS
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	337,143	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	80,033	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	88,322	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	250,376	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	58,707	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	1,840	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	1,134	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	2,031	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	22,188	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	147,089	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.98	07698 HYPERBARIIC OXYGEN THERAPY	0.000000	5,359	0	0	0	76.98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	151,460	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
95.00	09500 AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00	Total (lines 50 through 199)		1,145,682	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/23/2024 9:53 am
		Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.164677	0	0	263,929	0
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.516750	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.114663	0	0	481,946	0
55.00 05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0
56.00 05600 RADIOISOTOPE	0.000000	0	0	0	0
57.00 05700 CT SCAN	0.000000	0	0	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.115320	0	0	448,144	0
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.141116	0	0	99,220	0
66.00 06600 PHYSICAL THERAPY	0.340891	0	0	83,355	0
67.00 06700 OCCUPATIONAL THERAPY	0.584242	0	0	47,333	0
68.00 06800 SPEECH PATHOLOGY	0.337776	0	0	85,587	0
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.237118	0	0	33,684	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.259974	0	0	3,308	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.247035	0	0	138,059	0
74.00 07400 RENAL DIALYSIS	0.000000	0	0	0	0
75.00 07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.204513	0	0	36,210	0
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800 RURAL HEALTH CLINIC					88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER					89.00
90.00 09000 CLINIC	0.387827	0	0	0	0
91.00 09100 EMERGENCY	0.082902	0	0	1,059,123	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.047378	0	0	95,779	0
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00 09400 HOME PROGRAM DIALYSIS	0.000000	0	0	0	94.00
95.00 09500 AMBULANCE SERVICES	0.379885	0	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	97.00
200.00 Subtotal (see instructions)		0	0	2,875,677	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0	201.00
202.00 Net Charges (line 200 - line 201)		0	0	2,875,677	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/23/2024 9:53 am
	Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	43,463		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	55,261		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	51,680		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	14,002		65.00
66.00 06600 PHYSICAL THERAPY	0	28,415		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	27,654		67.00
68.00 06800 SPEECH PATHOLOGY	0	28,909		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,987		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	860		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	34,105		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	7,405		76.98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800 RURAL HEALTH CLINIC				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	87,803		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	100,317		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94.00
95.00 09500 AMBULANCE SERVICES	0	0		95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00	Subtotal (see instructions)	0	487,861	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	487,861	202.00



COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/23/2024 9:53 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,975	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,975	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)		4,595	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)		1,016	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)		7,990,286	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		7,990,286	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		7,990,286	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,145.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,163,889	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,163,889	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/23/2024 9:53 am	
Title XVIII			Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT	0	0	0.00	0	0	44.00
45.00 BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00
46.00 SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,072,105	48.00
48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00 Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					2,235,994	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)					73,040	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					69,000	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					142,040	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					2,093,954	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
55.01 Permanent adjustment amount per discharge					0.00	55.01
55.02 Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only): for CAH, see instructions					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					2,380	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,145.56	88.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0146		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/23/2024 9:53 am	
Cost Center Description		Title XVIII		Hospital		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,726,433	89.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	501,420	7,990,286	0.062754	2,726,433	171,095	90.00
91.00	Nursing Program cost	0	7,990,286	0.000000	2,726,433	0	91.00
92.00	Allied health cost	0	7,990,286	0.000000	2,726,433	0	92.00
93.00	All other Medical Education	0	7,990,286	0.000000	2,726,433	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/23/2024 9:53 am
Cost Center Description		Title XIX	Hospital	PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			6,975 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			6,975 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)			4,595 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)			123 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)			462 15.00
16.00	Nursery days (title V or XIX only)			40 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)			7,990,286 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			7,990,286 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			7,990,286 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,145.56 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			140,904 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)			140,904 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/23/2024 9:53 am	
				Title XIX	Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	453,663	462	981.95	40	39,278	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					347,466	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)					527,648	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)					11,163	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					22,385	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					33,548	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					494,100	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only): for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,380	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,145.56	88.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0146		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/23/2024 9:53 am	
Cost Center Description		Title XIX		Hospital		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,726,433	89.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	501,420	7,990,286	0.062754	2,726,433	171,095	90.00
91.00	Nursing Program cost	0	7,990,286	0.000000	2,726,433	0	91.00
92.00	Allied health cost	0	7,990,286	0.000000	2,726,433	0	92.00
93.00	All other Medical Education	0	7,990,286	0.000000	2,726,433	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/23/2024 9:53 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		2,251,796	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
40.00	04000	SUBPROVIDER - I PF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.164677	634,106	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.516750	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.114663	1,529,775	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.115320	1,749,810	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.141116	522,193	65.00
66.00	06600	PHYSICAL THERAPY	0.340891	62,012	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.584242	31,143	67.00
68.00	06800	SPEECH PATHOLOGY	0.337776	31,507	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.237118	101,021	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.259974	95,432	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247035	1,049,608	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.204513	24,174	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.387827	0	90.00
91.00	09100	EMERGENCY	0.083496	1,842,255	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.047378	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	94.00
95.00	09500	AMBULANCE SERVICES			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	97.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,673,036	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		7,673,036	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/23/2024 9:53 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		255,895	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
40.00	04000	SUBPROVIDER - I/PF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		68,060	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.164677	337,143	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.516750	80,033	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.114663	88,322	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.115320	250,376	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.141116	58,707	65.00
66.00	06600	PHYSICAL THERAPY	0.340891	1,840	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.584242	1,134	67.00
68.00	06800	SPEECH PATHOLOGY	0.337776	2,031	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.237118	22,188	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.259974	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247035	147,089	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.204513	5,359	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	0.387827	0	90.00
91.00	09100	EMERGENCY	0.083496	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.047378	151,460	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	94.00
95.00	09500	AMBULANCE SERVICES			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	97.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,145,682	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		1,145,682	202.00



CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/23/2024 9:53 am
		Title XVIII	Hospital	PPS
				1.00
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
1.00	DRG Amounts Other than Outlier Payments			0 1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		2,096,463	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		642,649	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		0	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		24.15	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
5.01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)		0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)		0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)		0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
<b>Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment ( sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.97	30.00
31.00	Percentage of Medicaid patient days (see instructions)		21.53	31.00
32.00	Sum of lines 30 and 31		26.50	32.00
33.00	Allowable disproportionate share percentage (see instructions)		11.08	33.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/23/2024 9:53 am	
		Title XVIII	Hospital	PPS	
				1.00	
34.00	Disproportionate share adjustment (see instructions)			75,874	34.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
<b>Uncompensated Care Payment Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)	6,874,403,459	5,938,006,757		35.00
35.01	Factor 3 (see instructions)	0.000108058	0.000109886		35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	742,834	652,504		35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	555,599	164,017		35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	719,616			36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>					
40.00	Total Medicare discharges (see instructions)	0			40.00
41.00	Total ESRD Medicare discharges (see instructions)	0			41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0			41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00			45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0			46.00
47.00	Subtotal (see instructions)	3,534,602			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	4,222,606			48.00
				<b>Amount</b>	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)		4,050,605		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		208,200		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
54.01	Islet isolation add-on payment		0		54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
55.01	Cellular therapy acquisition cost (see instructions)		0		55.01
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		4,258,805		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		4,258,805		61.00
62.00	Deductibles billed to program beneficiaries		398,172		62.00
63.00	Coinsurance billed to program beneficiaries		1,725		63.00
64.00	Allowable bad debts (see instructions)		71,509		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		46,481		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		21,949		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		3,905,389		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0		70.50
70.75	N95 respirator payment adjustment amount (see instructions)		0		70.75
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		1,074		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-1,406		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		4,924		70.93
70.94	HRR adjustment amount (see instructions)		0		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/23/2024 9:53 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2023	454,126	70.97
70.98	Low Volume Payment-3	2024	148,321	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		4,512,428	71.00
71.01	Sequestration adjustment (see instructions)		90,249	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		4,158,199	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		263,980	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		87,510	75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
<b>HSP Bonus Payment Amount</b>				
100.00	HSP bonus amount (see instructions)		385,942	130,061
<b>HVBP Adjustment for HSP Bonus Payment</b>				
101.00	HVBP adjustment factor (see instructions)		1.0000000000	1.0082607283
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	1,074
<b>HRR Adjustment for HSP Bonus Payment</b>				
103.00	HRR adjustment factor (see instructions)		0.9974	0.9969
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		-1,003	-403
<b>Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment</b>				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
<b>Cost Reimbursement</b>				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
<b>Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)</b>				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
<b>Adjustment to Medicare Part A Inpatient Reimbursement</b>				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
<b>Comparison of PPS versus Cost Reimbursement</b>				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0146		Period: From 01/01/2023 To 12/31/2023		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/23/2024 9:53 am	
		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,096,463	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	642,649		2,540,745	2,540,745	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1108	0.1108	0.1108		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	75,874	0	75,874	75,874	11.00
11.01	Uncompensated care payments	36.00	719,616	555,625	164,017	719,642	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	3,534,602	555,625	2,978,977	3,534,602	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	4,222,606	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,050,605	555,625	3,494,980	4,050,605	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	208,200	0	208,200	208,200	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	<b>SUBTOTAL</b>			555,625	3,703,180	4,258,805	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/23/2024 9:53 am	
Title XVIII			Hospital		PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	208,200	0	208,200	208,200	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	208,200	0	208,200	208,200	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00		70.96	0	0		0	27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	454,126		454,126	454,126	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	4,924	0	4,924	4,924	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	1,074	0	1,074	1,074	30.01
31.00	HRR adjustment (see instructions)	70.94	0	6,904	-6,904	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-1,406	-1,003	-403	-1,406	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/23/2024 9:53 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		4,739,717	2.00
3.00	OPPTS or REH payments		4,264,953	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.864	5.00
6.00	Line 2 times line 5		4,095,115	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		4,264,953	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		780,298	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		3,484,655	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
28.50	REH facility payment amount (see instructions)			28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)		3,484,655	30.00
31.00	Primary payer payments		604	31.00
32.00	Subtotal (line 30 minus line 31)		3,484,051	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		69,260	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		45,019	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		28,044	36.00
37.00	Subtotal (see instructions)		3,529,070	37.00
38.00	MSP-LCC reconciliation amount from PS&R		50	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.75	N95 respirator payment adjustment amount (see instructions)		0	39.75
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,529,020	40.00
40.01	Sequestration adjustment (see instructions)		70,580	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		3,427,583	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		30,857	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/23/2024 9:53 am
		Title XVIII	Hospital	PPS
				1.00
94.00	Total (sum of lines 91 and 93)			0 94.00
				1.00
200.00	MEDICARE PART B ANCILLARY COSTS Part B Combined Billed Days			0 200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0146

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/23/2024 9:53 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		4,158,199		3,427,583	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,158,199		3,427,583	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		263,980		30,857	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		4,422,179		3,458,440	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00



CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 15-0146

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

Worksheet E-1  
Part II  
Date/Time Prepared:  
5/23/2024 9:53 am

Title XVIII		Hospital	PPS
			1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS  
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/23/2024 9:53 am
Title XVIII			PPS	
			1.00	
<b>TO BE COMPLETED BY CONTRACTOR</b>				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	1.00
2.00	Capital outlier from Wkst. L, Pt. 1, line 2		0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)		0	4.00
5.00	The rate used to calculate the time value of money (see instructions)		0.00	5.00
6.00	Time value of money for operating expenses (see instructions)		0	6.00
7.00	Time value of money for capital related expenses (see instructions)		0	7.00

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

Provider CCN: 15-0146

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

Worksheet G

Date/Time Prepared:  
5/23/2024 9:53 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	34,923	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	25,071,970	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-14,453,104	0	0	0	6.00
7.00	Inventory	562,581	0	0	0	7.00
8.00	Prepaid expenses	48,523	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	43,199,136	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	54,464,029	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	755,392	0	0	0	13.00
14.00	Accumulated depreciation	-707,883	0	0	0	14.00
15.00	Buildings	4,270,602	0	0	0	15.00
16.00	Accumulated depreciation	-2,730,105	0	0	0	16.00
17.00	Leasehold improvements	1,415,776	0	0	0	17.00
18.00	Accumulated depreciation	-798,755	0	0	0	18.00
19.00	Fixed equipment	180,080	0	0	0	19.00
20.00	Accumulated depreciation	-107,293	0	0	0	20.00
21.00	Automobiles and trucks	1,474,271	0	0	0	21.00
22.00	Accumulated depreciation	-876,288	0	0	0	22.00
23.00	Major movable equipment	12,361,679	0	0	0	23.00
24.00	Accumulated depreciation	-9,698,148	0	0	0	24.00
25.00	Minor equipment depreciable	790,709	0	0	0	25.00
26.00	Accumulated depreciation	-331,036	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)	5,999,001	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	55,910	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	55,910	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	60,518,940	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	1,226,765	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,094,141	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	228,053	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	2,176,042	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,725,001	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	397,504	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	397,504	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,122,505	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	55,396,435				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)	55,396,435	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	60,518,940	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0146

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

Worksheet G-1

Date/Time Prepared:  
5/23/2024 9:53 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		47,256,593			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		7,566,993				2.00
3.00	Total (sum of line 1 and line 2)		54,823,586			0	3.00
4.00	HOME OFFICE INTEREST EXPENSE	461,036		0		0	4.00
5.00	ASSET TRANSFERS	111,813		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)		572,849			0	10.00
11.00	Subtotal (line 3 plus line 10)		55,396,435			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		55,396,435			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	HOME OFFICE INTEREST EXPENSE		0				4.00
5.00	ASSET TRANSFERS		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			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: 15-0146

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/23/2024 9:53 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
<b>General Inpatient Routine Services</b>					
1.00	Hospital	11,140,312		11,140,312	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	0		0	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	0		0	8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	11,140,312		11,140,312	10.00
<b>Intensive Care Type Inpatient Hospital Services</b>					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	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)	11,140,312		11,140,312	17.00
18.00	Ancillary services	39,893,017		39,893,017	18.00
19.00	Outpatient services	0	188,887,258	188,887,258	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	24,094,551	24,094,551	23.00
24.00	CMHC		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE	0	0	0	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)	51,033,329	212,981,809	264,015,138	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		67,169,496		29.00
30.00	HOME OFFICE EXPENSE	461,036			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)		461,036		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)		67,630,532		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet G-3 Date/Time Prepared: 5/23/2024 9:53 am
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	264,015,138	1.00
2.00	Less contractual allowances and discounts on patients' accounts	190,301,189	2.00
3.00	Net patient revenues (line 1 minus line 2)	73,713,949	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	67,630,532	4.00
5.00	Net income from service to patients (line 3 minus line 4)	6,083,417	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	58,156	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	167,397	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	627,628	24.00
24.01		630,395	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	1,483,576	25.00
26.00	Total (line 5 plus line 25)	7,566,993	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	7,566,993	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0146	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/23/2024 9:53 am
		Title XVII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		208,200	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		12.87	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		208,200	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00