

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet S Parts I-III Date/Time Prepared: 11/22/2023 10:37 am
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PART I - COST REPORT STATUS

Provider use only 1. Electronically prepared cost report Date: 11/22/2023 Time: 10:37 am
 2. Manually prepared cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ASCENSION ST. VINCENT ANDERSON (15-0088) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
1		2		
1	<i>Becky Jacobson</i>	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	Becky Jacobson		2
3	Signatory Title	VP OF FINANCE		3
4	Date	11/22/2023 10:37:56 AM		4

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	682,838	12,728	0	0 1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	0 2.00
3.00	SUBPROVIDER - IRF	0	-42,142	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
200.00	TOTAL	0	640,696	12,728	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: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 11/22/2023 10:37 am
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1.00	2.00	3.00	4.00
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Hospital and Hospital Health Care Complex Address:			
1.00	Street: 2015 JACKSON STREET	PO Box:	1.00
2.00	City: ANDERSON	State: IN	2.00
		Zip Code: 46016	
		County:	

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
						V	XVIII	XIX	
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		

Hospital and Hospital-Based Component Identification:										
3.00	Hospital	ASCENSION ST. VINCENT ANDERSON	150088	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	BENNETT REHAB CENTER	15T088	26900	5	06/01/1989	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2022	06/30/2023	20.00
21.00	Type of Control (see instructions)	1		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	Y				22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N	N			22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.									22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0088		Period: From 07/01/2022 To 06/30/2023		Worksheet S-2 Part I Date/Time Prepared: 11/22/2023 10:37 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.	1,170	309	0	13	6,385	15	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.	37	22	0	0	337		25.00	
				Urban/Rural		Date of Geogr			
				1.00		2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
				Beginning:		Ending:			
				1.00		2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
				Y/N		Y/N			
				1.00		2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
				V		XVIII		XIX	
				1.00		2.00		3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete wkst. L, Pt. III and wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete worksheet E-4.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete wkst. D-5.								58.00

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		V	XVIII	XIX			
		1.00	2.00	3.00			
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete wkst. D-2, Pt. I.	N			59.00		
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y		60.00		
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.01	1	60.01		
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20	
						1.00	
		ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
		Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N	63.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet S-2
Part I
Date/Time Prepared:
11/22/2023 10:37 am

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

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

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		V	XIX				
		1.00	2.00				
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y			98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y			98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y			98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N			98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N			98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y			98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y			98.06	
Rural Providers							
105.00	Does this hospital qualify as a CAH?	N				105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00	
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and worksheet E-2, lines 200 through 215, as applicable.					N	110.00
						1.00 2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N		111.00	
						1.00 2.00 3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0 115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			2		118.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 11/22/2023 10:37 am
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	0	0	1,152,796
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N	
119.00	DO NOT USE THIS LINE			
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N
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	
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.		Y	5.00
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.			
Certified Transplant Center Information				
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N	
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.			
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.			
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.			
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.			
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.			
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.			
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.			
133.00	Removed and reserved			
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.			
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	15H046
		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: ST VINCENT HEALTH	Contractor's Name: WPS		Contractor's Number: 08101
142.00	Street: 250 WEST 96TH STREET , SUITE 2058	PO Box:		
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46260	
		1.00	2.00	
144.00	Are provider based physicians' costs included in worksheet A?		Y	
		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.			
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0088		Period: From 07/01/2022 To 06/30/2023		Worksheet S-2 Part I Date/Time Prepared: 11/22/2023 10:37 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
							1.00	
							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	155.00
156.00	Subprovider - IPF						N	156.00
157.00	Subprovider - IRF						N	157.00
158.00	SUBPROVIDER						N	158.00
159.00	SNF						N	159.00
160.00	HOME HEALTH AGENCY						N	160.00
161.00	CMHC						N	161.00
							1.00	
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						9.99	169.00
							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: 15-0088		Period: From 07/01/2022 To 06/30/2023		Worksheet S-2 Part II Date/Time Prepared: 11/22/2023 10:37 am	
				Y/N	Date		
				1.00	2.00		
PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE							
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
				Y/N	Date		V/I
				1.00	2.00		3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					7.00
8.00	were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/30/2023	Y	10/30/2023		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N	N	21.00
					1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)						
Capital Related Cost						
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N		27.00
Interest Expense						
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N		31.00
Purchased Services						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N		33.00
Provider-Based Physicians						
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N		35.00
				Y/N	Date	
				1.00	2.00	
Home Office Costs						
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KATHY		ZAMBOS		41.00
42.00	Enter the employer/company name of the cost report preparer.	ST VINCENT HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	NA		KATHY.ZAMBOS@ASCENSION.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet S-2
Part II
Date/Time Prepared:
11/22/2023 10:37 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LEAD ANALYST	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: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet S-3
Part I
Date/Time Prepared:
11/22/2023 10:37 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / o/P		
	Line No.				Visits / Trips	Title V	
	1.00	2.00	3.00	4.00	5.00		
PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	123	44,895	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)		123	44,895	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	21	7,665	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		144	52,560	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	13	4,745		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		157				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: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet S-3
Part I
Date/Time Prepared:
11/22/2023 10:37 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,752	889	20,074		1.00
2.00	HMO and other (see instructions)	7,337	6,317			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	781	359			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,752	889	20,074		7.00
8.00	INTENSIVE CARE UNIT	2,482	219	4,041		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		452	547		13.00
14.00	Total (see instructions)	5,234	1,560	24,662	0.00	483.90
15.00	CAH visits	0	0	0		15.00
15.10	REH hours and visits					15.10
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF	1,122	37	2,677	0.00	13.51
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			140		24.10
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	497.41
28.00	Observation Bed Days		0	2,076		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			128		30.00
31.00	Employee discount days - IRF			15		31.00
32.00	Labor & delivery days (see instructions)	0	15	116		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: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet S-3
Part I
Date/Time Prepared:
11/22/2023 10:37 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
PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,036	211	5,034	1.00
2.00	HMO and other (see instructions)			1,181	1,652		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				34		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	1,036	211	5,034	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	95	3	221	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet S-3
Part II
Date/Time Prepared:
11/22/2023 10:37 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	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	45,606,462	50,096	45,656,558	1,034,619.17	44.13
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		52,538	0	52,538	238.82	219.99
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		16,540	0	16,540	1,002.68	16.50
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		5,178,914	159,119	5,338,033	118,856.05	44.91
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		5,706,529	0	5,706,529	121,867.78	46.83
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		1,780,095	0	1,780,095	20,403.58	87.24
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		11,148,528	0	11,148,528	211,329.00	52.75
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	wage-related costs (core) (see instructions)		11,134,081	0	11,134,081		
18.00	wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,300,212	0	1,300,212		
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		6,095	0	6,095		
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)		3,554,748	0	3,554,748		
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: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet S-3 Part II Date/Time Prepared: 11/22/2023 10:37 am
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	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
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	609,795	-608,452	1,343	31.27	42.95	26.00
27.00	Administrative & General	2,093,628	-517,454	1,576,174	36,264.04	43.46	27.00
28.00	Administrative & General under contract (see inst.)	2,365,546	0	2,365,546	32,185.50	73.50	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	1,611	13	1,624	36.78	44.15	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)	2,418,980	0	2,418,980	84,962.95	28.47	33.00
34.00	Dietary	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)	804,983	0	804,983	25,363.27	31.74	35.00
36.00	Cafeteria	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	1,689,277	141,143	1,830,420	44,159.27	41.45	38.00
39.00	Central Services and Supply	376,431	5,834	382,265	15,451.36	24.74	39.00
40.00	Pharmacy	3,019,206	54,009	3,073,215	60,983.59	50.39	40.00
41.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	41.00
42.00	Social Service	0	0	0	0.00	0.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet S-3
Part III
Date/Time Prepared:
11/22/2023 10:37 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	51,179,431	50,096	51,229,527	1,176,128.21	43.56	1.00
2.00	Excluded area salaries (see instructions)	5,178,914	159,119	5,338,033	118,856.05	44.91	2.00
3.00	Subtotal salaries (line 1 minus line 2)	46,000,517	-109,023	45,891,494	1,057,272.16	43.41	3.00
4.00	Subtotal other wages & related costs (see inst.)	18,635,152	0	18,635,152	353,600.36	52.70	4.00
5.00	Subtotal wage-related costs (see inst.)	14,694,924	0	14,694,924	0.00	32.02	5.00
6.00	Total (sum of lines 3 thru 5)	79,330,593	-109,023	79,221,570	1,410,872.52	56.15	6.00
7.00	Total overhead cost (see instructions)	13,379,457	-924,907	12,454,550	299,438.03	41.59	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet S-3 Part IV Date/Time Prepared: 11/22/2023 10:37 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,787,054	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	276,875	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	4,064,974	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,505,938	9.00
10.00	Dental, Hearing and Vision Plan	129,692	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	31,004	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	255,066	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'workers' Compensation Insurance	4,106	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	3,209,854	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	3,452	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	10,614	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	11,278,629	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet S-3 Part V Date/Time Prepared: 11/22/2023 10:37 am
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	

PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	5,706,529	11,278,629	1.00
2.00	Hospital	5,706,529	11,278,629	2.00
3.00	SUBPROVIDER - IPF			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			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet S-10 Date/Time Prepared: 11/22/2023 10:37 am
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.217135	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		48,091,355	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?			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		177,118,732	6.00	
7.00	Medicaid cost (line 1 times line 6)		38,458,676	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00	
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	13,405,470	981,476	14,386,946	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,910,797	981,476	3,892,273	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 (line 21 minus line 22)	2,910,797	981,476	3,892,273	23.00
			1.00		
24.00	Does the amount on line 20 column 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	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		7,493,933	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		301,796	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		464,301	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		7,029,632	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,688,884	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		5,581,157	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,581,157	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0088		Period: From 07/01/2022 To 06/30/2023		Worksheet A			
Date/Time Prepared: 11/22/2023 10:37 am									
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)			
		1.00	2.00	3.00	4.00	5.00			
GENERAL SERVICE COST CENTERS									
1.00	00100	CAP REL COSTS-BLDG & FIXT		5,413,227		5,413,227	-4,260	5,408,967	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MAB		0		0	0	0	1.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	609,795	8,513,923		9,123,718	-658,548	8,465,170	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,093,628	52,970,948		55,064,576	-521,857	54,542,719	5.00
7.00	00700	OPERATION OF PLANT	1,611	5,586,433		5,588,044	13	5,588,057	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	330,967		330,967	0	330,967	8.00
9.00	00900	HOUSEKEEPING	0	2,847,481		2,847,481	0	2,847,481	9.00
10.00	01000	DIETARY	0	3,015,699		3,015,699	-1,949,739	1,065,960	10.00
11.00	01100	CAFETERIA	0	0		0	1,949,739	1,949,739	11.00
13.00	01300	NURSING ADMINISTRATION	1,689,277	1,024,614		2,713,891	141,143	2,855,034	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	376,431	238,533		614,964	5,834	620,798	14.00
15.00	01500	PHARMACY	3,019,206	638,432		3,657,638	54,009	3,711,647	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	122		122	0	122	16.00
23.00	02300	ALLIED HEALTH-EMS	0	0		0	0	0	23.00
23.01	02301	ALLIED HEALTH-RAD TECH	86,242	34,605		120,847	24,519	145,366	23.01
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	11,420,420	2,998,406		14,418,826	765,887	15,184,713	30.00
31.00	03100	INTENSIVE CARE UNIT	3,515,464	1,523,419		5,038,883	92,424	5,131,307	31.00
41.00	04100	SUBPROVIDER - IRF	1,122,462	268,921		1,391,383	103,774	1,495,157	41.00
43.00	04300	NURSERY	0	0		0	217,112	217,112	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	2,451,203	9,528,177		11,979,380	21,053	12,000,433	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,251,289	325,764		1,577,053	-563,168	1,013,885	52.00
53.00	05300	ANESTHESIOLOGY	0	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,016,033	1,056,888		3,072,921	-3,190	3,069,731	54.00
54.01	03440	MAMMOGRAPHY	293,630	443,273		736,903	2,441	739,344	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	290,438	547,107		837,545	2,414	839,959	54.02
54.03	03630	ULTRA SOUND	318,787	92,297		411,084	2,650	413,734	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	953,649	1,151,350		2,104,999	8,051	2,113,050	55.00
57.00	05700	CT SCAN	672,415	88,540		760,955	5,590	766,545	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	255,097	218,892		473,989	9,242	483,231	58.00
59.00	05900	CARDIAC CATHETERIZATION	797,846	263,916		1,061,762	9,889	1,071,651	59.00
60.00	06000	LABORATORY	0	6,844,234		6,844,234	0	6,844,234	60.00
65.00	06500	RESPIRATORY THERAPY	1,184,143	186,473		1,370,616	24,320	1,394,936	65.00
66.00	06600	PHYSICAL THERAPY	460,035	3,953,678		4,413,713	-1,594,636	2,819,077	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		0	1,273,323	1,273,323	67.00
68.00	06800	SPEECH PATHOLOGY	0	0		0	433,764	433,764	68.00
69.00	06900	ELECTROCARDIOLOGY	130,780	65,151		195,931	1,087	197,018	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	223,169	375,374		598,543	1,855	600,398	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,731,323		3,731,323	0	3,731,323	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,308,565		5,308,565	0	5,308,565	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,565,392		15,565,392	0	15,565,392	73.00
76.00	03190	CHEMOTHERAPY	713,428	220,438		933,866	19,088	952,954	76.00
76.01	03020	WOUND CARE	403,291	511,243		914,534	3,456	917,990	76.01
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0		0	0	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	1,183,411	101,017		1,284,428	9,861	1,294,289	90.01
90.02	04950	DIABETIC EDUCATION	0	0		0	0	0	90.02
90.03	09002	MS CLINIC	0	0		0	0	0	90.03
91.00	09100	EMERGENCY	4,103,072	2,687,795		6,790,867	59,322	6,850,189	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	1,437		1,437	0	1,437	95.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE	0	0		0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,636,252	138,674,054		180,310,306	-53,538	180,256,768	118.00
NONREIMBURSABLE COST CENTERS									
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0	0	0	190.00
191.00	19100	RESEARCH	83,031	26,284		109,315	690	110,005	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,791,574	393,189		3,184,763	14,757	3,199,520	192.00
194.00	07950	FOUNDATION	0	0		0	0	0	194.00
194.01	07951	CHILDRENS CLINIC	0	0		0	0	0	194.01
194.02	07952	PSS ADMINISTRATION	43,910	10,654		54,564	365	54,929	194.02
194.03	07953	SEXUAL ASSAULT PROGRAM	5,482	400		5,882	46	5,928	194.03
194.04	07954	ASPR BIOTERRORISM GRANT	0	440		440	0	440	194.04
194.05	07955	HEALTHY FAMILIES	363,391	132,257		495,648	5,673	501,321	194.05
194.06	07956	DME-HOME CARE	0	2,747		2,747	0	2,747	194.06
194.07	07957	MARKETING	0	0		0	0	0	194.07
194.08	07958	CORPORATE COMMUNICATIONS	0	0		0	0	0	194.08
194.09	07959	MOB	0	369		369	0	369	194.09
194.10	07960	ASC	152	11		163	2	165	194.10

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0088		Period: From 07/01/2022 To 06/30/2023	Worksheet A Date/Time Prepared: 11/22/2023 10:37 am		
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
194.11	07961 MAB	0	0	0	0	0	194.11
194.12	07963 ADOLESCENT RESIDENTIAL SERVICES	682,670	75,777	758,447	32,005	790,452	194.12
194.13	07962 IDLE SPACE	0	0	0	0	0	194.13
200.00	TOTAL (SUM OF LINES 118 through 199)	45,606,462	139,316,182	184,922,644	0	184,922,644	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet A
Date/Time Prepared:
11/22/2023 10:37 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-525,588	4,883,379	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MAB	0	0	1.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-141,243	8,323,927	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-16,865,637	37,677,082	5.00
7.00	00700	OPERATION OF PLANT	-359,093	5,228,964	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	330,967	8.00
9.00	00900	HOUSEKEEPING	0	2,847,481	9.00
10.00	01000	DIETARY	-408,873	657,087	10.00
11.00	01100	CAFETERIA	0	1,949,739	11.00
13.00	01300	NURSING ADMINISTRATION	-168,193	2,686,841	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-610,317	10,481	14.00
15.00	01500	PHARMACY	-21,669	3,689,978	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-88	34	16.00
23.00	02300	ALLIED HEALTH-EMS	0	0	23.00
23.01	02301	ALLIED HEALTH-RAD TECH	-26,774	118,592	23.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-749	15,183,964	30.00
31.00	03100	INTENSIVE CARE UNIT	-376,860	4,754,447	31.00
41.00	04100	SUBPROVIDER - IRF	0	1,495,157	41.00
43.00	04300	NURSERY	0	217,112	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,208,179	10,792,254	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-2,153	1,011,732	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-60,858	3,008,873	54.00
54.01	03440	MAMMOGRAPHY	0	739,344	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	839,959	54.02
54.03	03630	ULTRA SOUND	-2,140	411,594	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,113,050	55.00
57.00	05700	CT SCAN	0	766,545	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-6,300	476,931	58.00
59.00	05900	CARDIAC CATHETERIZATION	-213	1,071,438	59.00
60.00	06000	LABORATORY	0	6,844,234	60.00
65.00	06500	RESPIRATORY THERAPY	-4,643	1,390,293	65.00
66.00	06600	PHYSICAL THERAPY	-10,346	2,808,731	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,273,323	67.00
68.00	06800	SPEECH PATHOLOGY	0	433,764	68.00
69.00	06900	ELECTROCARDIOLOGY	-495	196,523	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-316,826	283,572	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,731,323	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,308,565	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,565,392	73.00
76.00	03190	CHEMOTHERAPY	-342	952,612	76.00
76.01	03020	WOUND CARE	-20,000	897,990	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	-50,009	1,244,280	90.01
90.02	04950	DIABETIC EDUCATION	0	0	90.02
90.03	09002	MS CLINIC	0	0	90.03
91.00	09100	EMERGENCY	-970,891	5,879,298	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-1,437	0	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-22,159,916	158,096,852	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	110,005	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,199,520	192.00
194.00	07950	FOUNDATION	0	0	194.00
194.01	07951	CHILDRENS CLINIC	0	0	194.01
194.02	07952	PSS ADMINISTRATION	0	54,929	194.02
194.03	07953	SEXUAL ASSAULT PROGRAM	0	5,928	194.03
194.04	07954	ASPR BIOTERRORISM GRANT	0	440	194.04
194.05	07955	HEALTHY FAMILIES	0	501,321	194.05
194.06	07956	DME-HOME CARE	0	2,747	194.06
194.07	07957	MARKETING	0	0	194.07
194.08	07958	CORPORATE COMMUNICATIONS	0	0	194.08
194.09	07959	MOB	0	369	194.09
194.10	07960	ASC	0	165	194.10
194.11	07961	MAB	0	0	194.11
194.12	07963	ADOLESCENT RESIDENTIAL SERVICES	0	790,452	194.12

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet A Date/Time Prepared: 11/22/2023 10:37 am
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Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
194.13	07962 IDLE SPACE	0	0	194.13
200.00	TOTAL (SUM OF LINES 118 through 199)	-22,159,916	162,762,728	200.00

RECLASSIFICATIONS

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet A-6
Date/Time Prepared:
11/22/2023 10:37 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
C - INTEREST EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,260	1.00
	TOTALS		0	4,260	
D - CAFETERIA/DIETARY RECLASS					
1.00	CAFETERIA	11.00	0	1,949,739	1.00
	TOTALS		0	1,949,739	
E - LABOR DELIVERY RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	282,872	73,644	1.00
2.00	NURSERY	43.00	172,264	44,848	2.00
	TOTALS		455,136	118,492	
H - PT_OT_ST RECLASS					
1.00	OCCUPATIONAL THERAPY	67.00	132,717	1,140,606	1.00
2.00	SPEECH PATHOLOGY	68.00	45,211	388,553	2.00
	TOTALS		177,928	1,529,159	
J - ADOLESCENT RESIDENTIAL SERVICES					
1.00	ADOLESCENT RESIDENTIAL SERVICES	194.12	0	22,712	1.00
	TOTALS		0	22,712	
M - RAD TECH RECLASS					
1.00	ALLIED HEALTH-RAD TECH	23.01	23,805	0	1.00
	TOTALS		23,805	0	
O - SYSTEM PROJECTS					
1.00	NURSING ADMINISTRATION	13.00	122,305	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	276,862	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	40,800	0	3.00
4.00	SUBPROVIDER - IRF	41.00	78,935	0	4.00
5.00	RADIOLOGY-THERAPEUTIC	55.00	119	0	5.00
6.00	RESPIRATORY THERAPY	65.00	3,924	0	6.00
7.00	CHEMOTHERAPY	76.00	12,945	0	7.00
8.00	EMERGENCY	91.00	1,165	0	8.00
	TOTALS		537,055	0	
Q - PHYSICIAN RECLASS					
1.00	RESPIRATORY THERAPY	65.00	0	8,663	1.00
	TOTALS		0	8,663	
W - ACCRUED PTO					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	50,096	0	1.00
	TOTALS		50,096	0	
X - STARP					
1.00		0.00	0	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	16,493	0	2.00
3.00	OPERATION OF PLANT	7.00	13	0	3.00
4.00	NURSING ADMINISTRATION	13.00	14,023	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	3,129	0	5.00
6.00	PHARMACY	15.00	25,098	0	6.00
7.00	ALLIED HEALTH-RAD TECH	23.01	714	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	97,387	0	8.00
9.00	INTENSIVE CARE UNIT	31.00	29,223	0	9.00
10.00	SUBPROVIDER - IRF	41.00	8,925	0	10.00
11.00	OPERATING ROOM	50.00	20,376	0	11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	10,402	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	16,621	0	13.00
14.00	MAMMOGRAPHY	54.01	2,441	0	14.00
15.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.02	2,414	0	15.00
16.00	ULTRA SOUND	54.03	2,650	0	16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00	7,927	0	17.00
18.00	CT SCAN	57.00	5,590	0	18.00
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	2,121	0	19.00
20.00	CARDIAC CATHETERIZATION	59.00	6,632	0	20.00
21.00	RESPIRATORY THERAPY	65.00	9,844	0	21.00
22.00	PHYSICAL THERAPY	66.00	3,824	0	22.00
23.00	ELECTROCARDIOLOGY	69.00	1,087	0	23.00
24.00	ELECTROENCEPHALOGRAPHY	70.00	1,855	0	24.00
25.00	CHEMOTHERAPY	76.00	5,931	0	25.00
26.00	WOUND CARE	76.01	3,352	0	26.00
27.00	ANDERSON OUTPATIENT CENTER	90.01	9,837	0	27.00
28.00	EMERGENCY	91.00	34,117	0	28.00
29.00	RESEARCH	191.00	690	0	29.00
30.00	PHYSICIANS' PRIVATE OFFICES	192.00	13,185	0	30.00
31.00	PSS ADMINISTRATION	194.02	365	0	31.00
32.00	SEXUAL ASSAULT PROGRAM	194.03	46	0	32.00
33.00	HEALTHY FAMILIES	194.05	3,021	0	33.00
34.00	ASC	194.10	2	0	34.00

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
35.00	ADOLESCENT RESIDENTIAL SERVICES	194.12	5,675	0	35.00
	TOTALS		365,010	0	
Z - PTO CASH OUT					
1.00	ADMINISTRATIVE & GENERAL	5.00	3,108	0	1.00
2.00	NURSING ADMINISTRATION	13.00	4,815	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	2,705	0	3.00
4.00	PHARMACY	15.00	28,911	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	57,834	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	22,401	0	6.00
7.00	SUBPROVIDER - IRF	41.00	15,914	0	7.00
8.00	OPERATING ROOM	50.00	677	0	8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	58	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	3,994	0	10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	5	0	11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	7,121	0	12.00
13.00	CARDIAC CATHETERIZATION	59.00	3,257	0	13.00
14.00	RESPIRATORY THERAPY	65.00	1,889	0	14.00
15.00	PHYSICAL THERAPY	66.00	108,627	0	15.00
16.00	CHEMOTHERAPY	76.00	212	0	16.00
17.00	WOUND CARE	76.01	104	0	17.00
18.00	ANDERSON OUTPATIENT CENTER	90.01	24	0	18.00
19.00	EMERGENCY	91.00	24,040	0	19.00
20.00	PHYSICIANS' PRIVATE OFFICES	192.00	1,572	0	20.00
21.00	HEALTHY FAMILIES	194.05	2,652	0	21.00
22.00	ADOLESCENT RESIDENTIAL SERVICES	194.12	3,618	0	22.00
	TOTALS		293,538	0	
500.00	Grand Total: Increases		1,902,568	3,633,025	500.00

		Decreases					
Cost Center		Line #	Salary	Other	wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
C - INTEREST EXPENSE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,260	11		1.00
	TOTALS		0	4,260			
D - CAFETERIA/DIETARY RECLASS							
1.00	DIETARY	10.00	0	1,949,739	0		1.00
	TOTALS		0	1,949,739			
E - LABOR DELIVERY RECLASS							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	455,136	118,492	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		455,136	118,492			
H - PT_OT_ST RECLASS							
1.00	PHYSICAL THERAPY	66.00	177,928	1,529,159	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		177,928	1,529,159			
J - ADOLESCENT RESIDENTIAL SERVICES							
1.00	ADULTS & PEDIATRICS	30.00	0	22,712	0		1.00
	TOTALS		0	22,712			
M - RAD TECH RECLASS							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	23,805	0	0		1.00
	TOTALS		23,805	0			
O - SYSTEM PROJECTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	537,055	0	0		1.00
2.00		0.00	0	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
	TOTALS		537,055	0			
Q - PHYSICIAN RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,663	0		1.00
	TOTALS		0	8,663			
W - ACCRUED PTO							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	50,096	0		1.00
	TOTALS		0	50,096			
X - STARP							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	365,010	0	0		1.00
2.00		0.00	0	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
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0	0		31.00
32.00		0.00	0	0	0		32.00
33.00		0.00	0	0	0		33.00
34.00		0.00	0	0	0		34.00
35.00		0.00	0	0	0		35.00
	TOTALS		365,010	0			

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet A-6
Date/Time Prepared:
11/22/2023 10:37 am

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
Z - PTO CASH OUT						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	293,538	0	0	1.00
2.00		0.00	0	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
18.00		0.00	0	0	0	18.00
19.00		0.00	0	0	0	19.00
20.00		0.00	0	0	0	20.00
21.00		0.00	0	0	0	21.00
22.00		0.00	0	0	0	22.00
TOTALS			293,538	0		
500.00	Grand Total: Decreases		1,852,472	3,683,121		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet A-7
Part I
Date/Time Prepared:
11/22/2023 10:37 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	5,292,602	0	0	0	1.00
2.00	Land Improvements	2,926,143	42,581	0	42,581	2.00
3.00	Buildings and Fixtures	69,925,350	1,002,034	0	1,002,034	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	41,558,039	1,866,756	0	1,866,756	5.00
6.00	Movable Equipment	62,371,330	6,322,362	0	6,322,362	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	182,073,464	9,233,733	0	9,233,733	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	182,073,464	9,233,733	0	9,233,733	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	5,292,602	0			1.00
2.00	Land Improvements	2,968,724	0			2.00
3.00	Buildings and Fixtures	70,927,384	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	43,424,795	0			5.00
6.00	Movable Equipment	58,973,054	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	181,586,559	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	181,586,559	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet A-7
Part II
Date/Time Prepared:
11/22/2023 10:37 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	4,807,153	0	606,074	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MAB	0	0	0	0	0	1.01
3.00	Total (sum of lines 1-2)	4,807,153	0	606,074	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	5,413,227			1.00	
1.01	CAP REL COSTS-BLDG & FIXT-MAB	0	0			1.01	
3.00	Total (sum of lines 1-2)	0	5,413,227			3.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet A-7
Part III
Date/Time Prepared:
11/22/2023 10:37 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	181,586,559	0	181,586,559	1.000000	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MAB	0	0	0	0.000000	0	1.01
3.00	Total (sum of lines 1-2)	181,586,559	0	181,586,559	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	4,807,153	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MAB	0	0	0	0	0	1.01
3.00	Total (sum of lines 1-2)	0	0	0	4,807,153	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	76,226	0	0	0	4,883,379	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MAB	0	0	0	0	0	1.01
3.00	Total (sum of lines 1-2)	76,226	0	0	0	4,883,379	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet A-8

Date/Time Prepared:
11/22/2023 10:37 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7	Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-521,862	CAP REL COSTS-BLDG & FIXT	1.00		11	1.00
1.01 Investment income - CAP REL COSTS-BLDG & FIXT-MAB (chapter 2)		0	CAP REL COSTS-BLDG & FIXT-MAB	1.01			1.01
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00			2.00
3.00 Investment income - other (chapter 2)	B	-84,212	ADMINISTRATIVE & GENERAL	5.00		11	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00			4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00			5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00			6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-15,644	ADMINISTRATIVE & GENERAL	5.00			7.00
8.00 Television and radio service (chapter 21)	A	-6,731	OPERATION OF PLANT	7.00			8.00
9.00 Parking lot (chapter 21)		0		0.00			9.00
10.00 Provider-based physician adjustment	A-8-2	-2,944,166					10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00			11.00
12.00 Related organization transactions (chapter 10)	A-8-1	2,875,755					12.00
13.00 Laundry and linen service		0		0.00			13.00
14.00 Cafeteria-employees and guests	B	-370,438	DIETARY	10.00			14.00
15.00 Rental of quarters to employee and others		0		0.00			15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00			16.00
17.00 Sale of drugs to other than patients	B	-28	PHARMACY	15.00			17.00
18.00 Sale of medical records and abstracts	B	-140	ADMINISTRATIVE & GENERAL	5.00			18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00			19.00
20.00 Vending machines	B	-38,435	DIETARY	10.00			20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00			21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00			22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00			26.00
26.01 Depreciation - CAP REL COSTS-BLDG & FIXT-MAB		0	CAP REL COSTS-BLDG & FIXT-MAB	1.01			26.01
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00			27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant		0		0.00			29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00			30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet A-8

Date/Time Prepared:
11/22/2023 10:37 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
			Cost Center		Line #		
			1.00	2.00	3.00		4.00
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	LEASE INCOME	B	-348,222	OPERATION OF PLANT	7.00	0	33.00
33.01	AMBULANCE COST	B	-1,437	AMBULANCE SERVICES	95.00	0	33.01
33.02	SALE OF MEDICAL RECORDS	B	-88	MEDICAL RECORDS & LIBRARY	16.00	0	33.02
33.03	PHYSICIAN FUND EXPENSE	A	-6,102,184	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PHYSICIAN FUND EXPENSE	A	-1,047,854	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	SALE OF MEDICAL RECORDS	B	-1,983	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	PATIENT INTEREST INCOME	B	-2,296	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	LATE PENALTY FEE	B	117	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	LATE PENALTY FEE	B	-4,061	OPERATION OF PLANT	7.00	0	33.08
33.09	VB PHYSICIAN REVENUE	B	-590	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	TELEPHONE REVENUE	B	1,088	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	OTHER MISCELLANEOUS REVENUE	B	-190	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	OTHER MISCELLANEOUS REVENUE	B	-3,200	PHARMACY	15.00	0	33.12
33.13	OTHER MISCELLANEOUS REVENUE	B	-150	RADIOLOGY-DIAGNOSTIC	54.00	0	33.13
33.14	OTHER MISCELLANEOUS REVENUE	B	-6,300	MAGNETIC RESONANCE IMAGING (MRI)	58.00	9	33.14
33.15	OTHER MISCELLANEOUS REVENUE	B	-3,060	RESPIRATORY THERAPY	65.00	0	33.15
33.16	OTHER MISCELLANEOUS REVENUE	B	-10,346	PHYSICAL THERAPY	66.00	0	33.16
33.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.17
33.18	ENTERTAINMENT	A	-24,988	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	ENTERTAINMENT	A	-79	OPERATION OF PLANT	7.00	0	33.19
33.20	ENTERTAINMENT	A	-328	NURSING ADMINISTRATION	13.00	0	33.20
36.00	ENTERTAINMENT	A	-368	ADULTS & PEDIATRICS	30.00	0	36.00
36.01	ENTERTAINMENT	A	-258	RADIOLOGY-DIAGNOSTIC	54.00	0	36.01
36.02	ENTERTAINMENT	A	-342	CHEMOTHERAPY	76.00	0	36.02
36.03	ENTERTAINMENT	A	-568	ANDERSON OUTPATIENT CENTER	90.01	0	36.03
36.04	ENTERTAINMENT	A	-245	EMERGENCY	91.00	0	36.04
36.05	GAIN/LOSS ON DISPOSAL PPE	B	-13	DELIVERY ROOM & LABOR ROOM	52.00	0	36.05
36.06	GAIN/LOSS ON DISPOSAL PPE	B	-213	CARDIAC CATHETERIZATION	59.00	0	36.06
36.07	TUITION REVENUE	B	-26,774	ALLIED HEALTH-RAD TECH	23.01	0	36.07
36.08	TUITION REVENUE	B	-2,140	ULTRA SOUND	54.03	0	36.08
36.09	MEDICAL STAFF DUES	B	-100	ADMINISTRATIVE & GENERAL	5.00	0	36.09
36.10	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	36.10
36.11	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	36.11
36.12	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.12
36.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.13
36.14	EQUIPMENT RENTAL	B	-6,262	OPERATING ROOM	50.00	0	36.14
36.15	CONTRACT SERVICE REVENUE	B	-31,441	ANDERSON OUTPATIENT CENTER	90.01	0	36.15
36.16	CHARITABLE CONTRIBUTIONS	A	-34,259	NURSING ADMINISTRATION	13.00	0	36.16
36.17	CHARITABLE CONTRIBUTION	A	-13,463	ADMINISTRATIVE & GENERAL	5.00	0	36.17
36.18	CORPORATE SPONSORSHIPS	A	-28,125	ADMINISTRATIVE & GENERAL	5.00	0	36.18
36.19	COMMUNITY BENEFITS	A	-1,260	ADMINISTRATIVE & GENERAL	5.00	0	36.19
36.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.20
36.21	STATE PROGRAM REVENUE	B	0		0.00	0	36.21
36.22	BILLING ARRANGEMENTS	B	-15,540	ADMINISTRATIVE & GENERAL	5.00	0	36.22
36.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.23
36.24	LOBBYING EXPENSE	A	-2,625	ADMINISTRATIVE & GENERAL	5.00	0	36.24
36.25	BILLING ARRANGEMENTS	B	-600	OPERATING ROOM	50.00	9	36.25
36.26	PROMOTIONAL ITEMS	A	-8,524	ADMINISTRATIVE & GENERAL	5.00	0	36.26
36.27	PROMOTIONAL ITEMS	A	-2,140	DELIVERY ROOM & LABOR ROOM	52.00	0	36.27
36.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.28
36.29	PROMOTIONAL ITEMS	A	-1,259	RESPIRATORY THERAPY	65.00	0	36.29
36.30	PROMOTIONAL ITEMS	A	-495	ELECTROCARDIOLOGY	69.00	0	36.30
36.31	PROVIDER TAX	A	-13,278,614	ADMINISTRATIVE & GENERAL	5.00	0	36.31
36.32	MARKETING EXPENSE	A	-5,090	ADMINISTRATIVE & GENERAL	5.00	0	36.32
36.33	MARKETING EXPENSE	A	-381	ADULTS & PEDIATRICS	30.00	0	36.33
36.34	MARKETING EXPENSE	A	-324	RESPIRATORY THERAPY	65.00	0	36.34

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet A-8

Date/Time Prepared:
11/22/2023 10:37 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
36.35 BILLING ARRANGEMENTS	B	-18,441	PHARMACY	15.00	0	36.35
36.36 BILLING ARRANGEMENTS	B	-18,000	ANDERSON OUTPATIENT CENTER	90.01	0	36.36
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-22,159,916				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: 15-0088

Period: From 07/01/2022 To 06/30/2023

Worksheet A-8-1

Date/Time Prepared: 11/22/2023 10:37 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 - CAPITAL	2,135,369	0
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - INTEREST - CA	79,296	0
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - A&G	656	0
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - OTHER	25,579,265	24,845,688
4.01	8.00	LAUNDRY & LINEN SERVICE	SVH CHARGEBACK	-16,348	-16,348
4.02	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACK	-33,504	-33,504
4.03	15.00	PHARMACY	SVH CHARGEBACK	-8,000	-8,000
4.04	23.01	ALLIED HEALTH-RAD TECH	SVH CHARGEBACK	28,370	28,370
4.05	50.00	OPERATING ROOM	SVH CHARGEBACK	490,000	490,000
4.06	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACK	20,675	20,675
4.07	55.00	RADIOLOGY-THERAPEUTIC	SVH CHARGEBACK	8,970	8,970
4.08	59.00	CARDIAC CATHETERIZATION	SVH CHARGEBACK	90,000	90,000
4.09	91.00	EMERGENCY	SVH CHARGEBACK	52,550	52,500
4.10	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	521,862	525,588
4.11	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	4,260	0
4.12	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	7,176,195	6,269,584
4.13	14.00	CENTRAL SERVICES & SUPPLY	TRG ADMIN FEES - SUPPLIES	-610,317	0
4.14	13.00	NURSING ADMINISTRATION	TRG ADMIN FEES - CONTRACTED	-133,606	0
4.15	5.00	ADMINISTRATIVE & GENERAL	TRG ADMIN FEES - OTHER	-236,415	0
4.16	0.00			0	0
4.17	0.00			0	0
4.18	0.00			0	0
4.19	0.00			0	0
4.20	0.00			0	0
4.21	0.00			0	0
4.22	0.00			0	0
4.23	0.00			0	0
4.24	0.00			0	0
4.25	0.00			0	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.			35,149,278	32,273,523

* 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	G	ST VINCENT HEAL	100.00	ST VINCENT HEAL	100.00	6.00
7.00	G	ASCENSION HEALT	100.00	ASCENSION HEALT	100.00	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:	FINANCIAL				100.00

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

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

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

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet A-8-1

Date/Time Prepared:
11/22/2023 10:37 am

	Net Adjustments (col. 4 minus col. 5)*	wkst. A-7 Ref.	
	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	2,135,369	0	1.00
2.00	79,296	0	2.00
3.00	656	0	3.00
4.00	733,577	0	4.00
4.01	0	0	4.01
4.02	0	0	4.02
4.03	0	0	4.03
4.04	0	0	4.04
4.05	0	0	4.05
4.06	0	0	4.06
4.07	0	0	4.07
4.08	0	0	4.08
4.09	50	0	4.09
4.10	-3,726	11	4.10
4.11	4,260	0	4.11
4.12	906,611	0	4.12
4.13	-610,317	0	4.13
4.14	-133,606	0	4.14
4.15	-236,415	0	4.15
4.16	0	0	4.16
4.17	0	0	4.17
4.18	0	0	4.18
4.19	0	0	4.19
4.20	0	0	4.20
4.21	0	0	4.21
4.22	0	0	4.22
4.23	0	0	4.23
4.24	0	0	4.24
4.25	0	0	4.25
5.00	2,875,755		5.00

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

Related Organization(s) and/or Home Office	Type of Business
	6.00

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	HOME OFFICE	6.00
7.00	SYSTEM OFFICE	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: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet A-8-2

Date/Time Prepared:
11/22/2023 10:37 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	31.00	INTENSIVE CARE UNIT	376,860	376,860	0	197,500	0	1.00
2.00	50.00	OPERATING ROOM	1,566,317	1,201,317	365,000	246,400	8,040	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	348,525	58,467	290,058	271,900	8,760	3.00
4.00	70.00	ELECTROENCEPHALOGRAPHY	316,826	316,826	0	179,000	0	4.00
5.00	76.01	WOUND CARE	20,000	20,000	0	179,000	0	5.00
6.00	91.00	EMERGENCY	970,696	970,696	0	179,000	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,599,224	2,944,166	655,058		16,800	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	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	952,431	47,622	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	1,145,117	57,256	0	0	0	3.00
4.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	4.00
5.00	76.01	WOUND CARE	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	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			2,097,548	104,878	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	31.00	INTENSIVE CARE UNIT	0	0	0	376,860		1.00
2.00	50.00	OPERATING ROOM	0	952,431	0	1,201,317		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	1,145,117	0	58,467		3.00
4.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	316,826		4.00
5.00	76.01	WOUND CARE	0	0	0	20,000		5.00
6.00	91.00	EMERGENCY	0	0	0	970,696		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	2,097,548	0	2,944,166		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet B
Part I
Date/Time Prepared:
11/22/2023 10:37 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	BLDG & FIXT-MAB			
	0	1.00	1.01	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	4,883,379	4,883,379			1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT-MAB	0	0	0		1.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	8,323,927	64,131	0	8,388,058	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	37,677,082	537,190	0	289,584	5.00
7.00 00700	OPERATION OF PLANT	5,228,964	577,286	0	298	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	330,967	6,949	0	0	8.00
9.00 00900	HOUSEKEEPING	2,847,481	103,316	0	0	9.00
10.00 01000	DIETARY	657,087	101,887	0	0	10.00
11.00 01100	CAFETERIA	1,949,739	186,357	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	2,686,841	50,576	0	336,296	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	10,481	164,238	0	70,232	14.00
15.00 01500	PHARMACY	3,689,978	49,903	0	564,629	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	34	53,993	0	0	16.00
23.00 02300	ALLIED HEALTH-EMS	0	0	0	0	23.00
23.01 02301	ALLIED HEALTH-RAD TECH	118,592	1,139	0	20,350	23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	15,183,964	696,552	0	2,229,592	30.00
31.00 03100	INTENSIVE CARE UNIT	4,754,447	151,811	0	662,863	31.00
41.00 04100	SUBPROVIDER - IRF	1,495,157	103,555	0	225,291	41.00
43.00 04300	NURSERY	217,112	57,670	0	31,649	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	10,792,254	497,031	0	454,218	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,011,732	219,028	0	148,196	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,008,873	147,855	0	369,812	54.00
54.01 03440	MAMMOGRAPHY	739,344	0	0	54,396	54.01
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	839,959	11,671	0	53,805	54.02
54.03 03630	ULTRA SOUND	411,594	0	0	59,056	54.03
55.00 05500	RADIOLOGY-THERAPEUTIC	2,113,050	0	0	176,689	55.00
57.00 05700	CT SCAN	766,545	5,706	0	124,567	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	476,931	10,387	0	48,566	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,071,438	88,663	0	148,402	59.00
60.00 06000	LABORATORY	6,844,234	129,899	0	0	60.00
65.00 06500	RESPIRATORY THERAPY	1,390,293	73,917	0	220,434	65.00
66.00 06600	PHYSICAL THERAPY	2,808,731	100,697	0	72,491	66.00
67.00 06700	OCCUPATIONAL THERAPY	1,273,323	47,376	0	24,384	67.00
68.00 06800	SPEECH PATHOLOGY	433,764	16,134	0	8,306	68.00
69.00 06900	ELECTROCARDIOLOGY	196,523	0	0	24,227	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	283,572	120,579	0	41,343	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,731,323	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	5,308,565	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	15,565,392	0	0	0	73.00
76.00 03190	CHEMOTHERAPY	952,612	0	0	134,582	76.00
76.01 03020	WOUND CARE	897,990	32,102	0	74,730	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	ANDERSON OUTPATIENT CENTER	1,244,280	36,244	0	219,235	90.01
90.02 04950	DIABETIC EDUCATION	0	0	0	0	90.02
90.03 09002	MS CLINIC	0	0	0	0	90.03
91.00 09100	EMERGENCY	5,879,298	234,396	0	764,740	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	158,096,852	4,678,238	0	7,652,963	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	19,489	0	0	190.00
191.00 19100	RESEARCH	110,005	0	0	15,382	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	3,199,520	18,940	0	515,596	192.00
194.00 07950	FOUNDATION	0	6,586	0	0	194.00
194.01 07951	CHILDRENS CLINIC	0	0	0	0	194.01
194.02 07952	PSS ADMINISTRATION	54,929	0	0	8,134	194.02
194.03 07953	SEXUAL ASSAULT PROGRAM	5,928	0	0	1,016	194.03
194.04 07954	ASPR BIOTERRORISM GRANT	440	0	0	0	194.04
194.05 07955	HEALTHY FAMILIES	501,321	104,497	0	67,807	194.05
194.06 07956	DME-HOME CARE	2,747	0	0	0	194.06
194.07 07957	MARKETING	0	0	0	0	194.07

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet B
Part I
Date/Time Prepared:
11/22/2023 10:37 am

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	BLDG & FIXT-MAB			
	0	1.00	1.01	4.00	4A	
194.08 07958 CORPORATE COMMUNICATIONS	0	26,168	0	0	26,168	194.08
194.09 07959 MOB	369	0	0	0	369	194.09
194.10 07960 ASC	165	0	0	28	193	194.10
194.11 07961 MAB	0	0	0	0	0	194.11
194.12 07963 ADOLESCENT RESIDENTIAL SERVICES	790,452	29,461	0	127,132	947,045	194.12
194.13 07962 IDLE SPACE	0	0	0	0	0	194.13
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	162,762,728	4,883,379	0	8,388,058	162,762,728	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet B
Part I
Date/Time Prepared:
11/22/2023 10:37 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MAB					1.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	38,503,856				5.00
7.00	00700	OPERATION OF PLANT	1,799,263	7,605,811			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	104,709	14,265	456,890		8.00
9.00	00900	HOUSEKEEPING	914,358	212,106	0	4,077,261	9.00
10.00	01000	DIETARY	235,182	209,173	0	115,571	1,318,900
11.00	01100	CAFETERIA	661,908	382,587	0	211,385	0
13.00	01300	NURSING ADMINISTRATION	952,445	103,832	0	57,369	0
14.00	01400	CENTRAL SERVICES & SUPPLY	75,902	337,176	0	186,295	0
15.00	01500	PHARMACY	1,333,830	102,450	0	56,605	0
16.00	01600	MEDICAL RECORDS & LIBRARY	16,741	110,847	0	61,245	0
23.00	02300	ALLIED HEALTH-EMS	0	0	0	0	0
23.01	02301	ALLIED HEALTH-RAD TECH	43,407	2,339	0	1,292	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,611,754	1,430,001	330,831	790,101	1,069,880
31.00	03100	INTENSIVE CARE UNIT	1,725,692	311,665	67,248	172,200	89,179
41.00	04100	SUBPROVIDER - IRF	565,200	212,595	44,549	117,462	112,494
43.00	04300	NURSERY	94,953	118,394	8,953	65,415	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,638,936	1,020,394	0	563,784	156
52.00	05200	DELIVERY ROOM & LABOR ROOM	427,294	449,660	0	248,445	17,268
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,092,762	303,544	0	167,713	0
54.01	03440	MAMMOGRAPHY	245,955	0	0	0	0
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	280,565	23,959	0	13,238	0
54.03	03630	ULTRA SOUND	145,839	0	0	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC	709,517	0	0	0	0
57.00	05700	CT SCAN	277,895	11,714	0	6,472	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	166,053	21,323	0	11,781	0
59.00	05900	CARDIAC CATHETERIZATION	405,463	182,024	0	100,571	10,087
60.00	06000	LABORATORY	2,161,061	266,680	0	147,345	0
65.00	06500	RESPIRATORY THERAPY	522,017	151,751	0	83,845	0
66.00	06600	PHYSICAL THERAPY	924,001	206,728	0	114,220	0
67.00	06700	OCCUPATIONAL THERAPY	416,798	97,262	0	53,739	0
68.00	06800	SPEECH PATHOLOGY	141,983	33,122	0	18,301	0
69.00	06900	ELECTROCARDIOLOGY	68,403	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	138,044	247,546	0	136,773	222
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,156,218	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,644,954	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	4,823,217	0	0	0	0
76.00	03190	CHEMOTHERAPY	336,887	0	0	0	12,902
76.01	03020	WOUND CARE	311,362	65,905	0	36,413	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	ANDERSON OUTPATIENT CENTER	464,727	74,408	0	41,112	0
90.02	04950	DIABETIC EDUCATION	0	0	0	0	0
90.03	09002	MS CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	2,131,407	481,210	5,309	265,876	6,712
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,766,702	7,184,660	456,890	3,844,568	1,318,900
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	6,039	40,010	0	22,106	0
191.00	19100	RESEARCH	38,853	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,157,064	38,884	0	21,484	0
194.00	07950	FOUNDATION	2,041	13,521	0	7,471	0
194.01	07951	CHILDRENS CLINIC	0	0	0	0	0
194.02	07952	PSS ADMINISTRATION	19,541	0	0	0	0
194.03	07953	SEXUAL ASSAULT PROGRAM	2,152	0	0	0	0
194.04	07954	ASPR BIOTERRORISM GRANT	136	0	0	0	0
194.05	07955	HEALTHY FAMILIES	208,735	214,530	0	118,531	0
194.06	07956	DME-HOME CARE	851	0	0	0	0
194.07	07957	MARKETING	0	0	0	0	0
194.08	07958	CORPORATE COMMUNICATIONS	8,109	53,723	0	29,683	0
194.09	07959	MOB	114	0	0	0	0
194.10	07960	ASC	60	0	0	0	0
194.11	07961	MAB	0	0	0	0	0
194.12	07963	ADOLESCENT RESIDENTIAL SERVICES	293,459	60,483	0	33,418	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet B
Part I
Date/Time Prepared:
11/22/2023 10:37 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
194.13	07962 IDLE SPACE	0	0	0	0	0	194.13
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)	38,503,856	7,605,811	456,890	4,077,261	1,318,900	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet B Part I Date/Time Prepared: 11/22/2023 10:37 am
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	3,391,976					11.00
13.00	01300	168,140	4,355,499				13.00
14.00	01400	58,831	0	903,155			14.00
15.00	01500	232,203	0	11,190	6,040,788		15.00
16.00	01600	0	0	3	0	242,863	16.00
23.00	02300	0	0	0	0	0	23.00
23.01	02301	11,073	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,025,452	2,041,830	35,251	0	18,191	30.00
31.00	03100	264,697	695,147	22,280	0	7,115	31.00
41.00	04100	107,013	221,585	1,450	0	1,768	41.00
43.00	04300	13,517	38,390	797	0	411	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	163,438	451,040	684,063	0	49,484	50.00
52.00	05200	68,906	177,424	3,682	0	1,380	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	215,804	0	29,658	0	5,641	54.00
54.01	03440	24,517	0	3,836	0	1,637	54.01
54.02	03450	21,700	0	16,057	0	5,624	54.02
54.03	03630	27,944	0	483	0	2,915	54.03
55.00	05500	94,486	0	1,614	0	11,648	55.00
57.00	05700	59,593	0	380	0	5,918	57.00
58.00	05800	22,096	0	83	0	927	58.00
59.00	05900	73,456	112,622	15,747	0	8,452	59.00
60.00	06000	0	0	196	0	30,024	60.00
65.00	06500	104,248	0	10,959	0	6,313	65.00
66.00	06600	27,045	0	2,974	0	3,093	66.00
67.00	06700	13,803	0	1,399	0	1,429	67.00
68.00	06800	4,702	0	477	0	487	68.00
69.00	06900	13,879	0	127	0	459	69.00
70.00	07000	8,263	0	472	0	1,406	70.00
71.00	07100	0	0	0	0	6,963	71.00
72.00	07200	0	0	0	0	7,468	72.00
73.00	07300	0	0	0	6,040,788	30,257	73.00
76.00	03190	80,074	0	6,860	0	2,602	76.00
76.01	03020	43,163	0	22,352	0	1,969	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	38,495	0	71	0	1,504	90.01
90.02	04950	0	0	0	0	0	90.02
90.03	09002	0	0	0	0	0	90.03
91.00	09100	314,984	617,461	30,662	0	27,778	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		3,301,522	4,355,499	903,123	6,040,788	242,863	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	7,943	0	0	0	0	191.00
192.00	19200	16,095	0	9	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	10,364	0	0	0	0	194.02
194.03	07953	461	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	55,591	0	0	0	0	194.05
194.06	07956	0	0	23	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	0	0	0	194.09
194.10	07960	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet B
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		11.00	13.00	14.00	15.00	16.00		
194.12	07963	ADOLESCENT RESIDENTIAL SERVICES	0	0	0	0	0	194.12
194.13	07962	IDLE SPACE	0	0	0	0	0	194.13
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)	3,391,976	4,355,499	903,155	6,040,788	242,863	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

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Part I
Date/Time Prepared:
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Cost Center Description			ALLIED HEALTH-EMS	ALLIED HEALTH-RAD TECH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.00	23.01	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MAB						1.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
23.00	02300	ALLIED HEALTH-EMS	0					23.00
23.01	02301	ALLIED HEALTH-RAD TECH		198,192				23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	30,463,399	0	30,463,399	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	8,924,344	0	8,924,344	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	3,208,119	0	3,208,119	41.00
43.00	04300	NURSERY	0	0	647,261	0	647,261	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	18,314,798	0	18,314,798	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	2,773,015	0	2,773,015	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,588	5,374,250	0	5,374,250	54.00
54.01	03440	MAMMOGRAPHY	0	9,460	1,079,145	0	1,079,145	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	32,490	1,299,068	0	1,299,068	54.02
54.03	03630	ULTRA SOUND	0	16,841	664,672	0	664,672	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	67,266	3,174,270	0	3,174,270	55.00
57.00	05700	CT SCAN	0	34,191	1,292,981	0	1,292,981	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,356	763,503	0	763,503	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	2,216,925	0	2,216,925	59.00
60.00	06000	LABORATORY	0	0	9,579,439	0	9,579,439	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	2,563,777	0	2,563,777	65.00
66.00	06600	PHYSICAL THERAPY	0	0	4,259,980	0	4,259,980	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,929,513	0	1,929,513	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	657,276	0	657,276	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	303,618	0	303,618	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	978,220	0	978,220	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	4,894,504	0	4,894,504	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	6,960,987	0	6,960,987	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	26,459,654	0	26,459,654	73.00
76.00	03190	CHEMOTHERAPY	0	0	1,526,519	0	1,526,519	76.00
76.01	03020	WOUND CARE	0	0	1,485,986	0	1,485,986	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	0	0	2,120,076	0	2,120,076	90.01
90.02	04950	DIABETIC EDUCATION	0	0	0	0	0	90.02
90.03	09002	MS CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	10,759,833	0	10,759,833	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	198,192	154,675,132	0	154,675,132	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	87,644	0	87,644	190.00
191.00	19100	RESEARCH	0	0	172,183	0	172,183	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,967,592	0	4,967,592	192.00
194.00	07950	FOUNDATION	0	0	29,619	0	29,619	194.00
194.01	07951	CHILDRENS CLINIC	0	0	0	0	0	194.01
194.02	07952	PSS ADMINISTRATION	0	0	92,968	0	92,968	194.02
194.03	07953	SEXUAL ASSAULT PROGRAM	0	0	9,557	0	9,557	194.03
194.04	07954	ASPR BIOTERRORISM GRANT	0	0	576	0	576	194.04
194.05	07955	HEALTHY FAMILIES	0	0	1,271,012	0	1,271,012	194.05
194.06	07956	DME-HOME CARE	0	0	3,621	0	3,621	194.06
194.07	07957	MARKETING	0	0	0	0	0	194.07
194.08	07958	CORPORATE COMMUNICATIONS	0	0	117,683	0	117,683	194.08
194.09	07959	MOB	0	0	483	0	483	194.09

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

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Cost Center Description			ALLIED HEALTH-EMS	ALLIED HEALTH-RAD TECH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.00	23.01	24.00	25.00	26.00	
194.10	07960	ASC	0	0	253	0	253	194.10
194.11	07961	MAB	0	0	0	0	0	194.11
194.12	07963	ADOLESCENT RESIDENTIAL SERVICES	0	0	1,334,405	0	1,334,405	194.12
194.13	07962	IDLE SPACE	0	0	0	0	0	194.13
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	198,192	162,762,728	0	162,762,728	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet B
Part II
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	BLDG & FIXT-MAB			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT-MAB					1.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	64,131	0	64,131	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,135,369	537,190	0	2,672,559	5.00
7.00 00700	OPERATION OF PLANT	0	577,286	0	577,286	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	6,949	0	6,949	8.00
9.00 00900	HOUSEKEEPING	0	103,316	0	103,316	9.00
10.00 01000	DIETARY	0	101,887	0	101,887	10.00
11.00 01100	CAFETERIA	0	186,357	0	186,357	11.00
13.00 01300	NURSING ADMINISTRATION	0	50,576	0	50,576	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	164,238	0	164,238	14.00
15.00 01500	PHARMACY	0	49,903	0	49,903	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	53,993	0	53,993	16.00
23.00 02300	ALLIED HEALTH-EMS	0	0	0	0	23.00
23.01 02301	ALLIED HEALTH-RAD TECH	0	1,139	0	1,139	23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	696,552	0	696,552	30.00
31.00 03100	INTENSIVE CARE UNIT	0	151,811	0	151,811	31.00
41.00 04100	SUBPROVIDER - IRF	0	103,555	0	103,555	41.00
43.00 04300	NURSERY	0	57,670	0	57,670	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	497,031	0	497,031	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	219,028	0	219,028	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	147,855	0	147,855	54.00
54.01 03440	MAMMOGRAPHY	0	0	0	0	54.01
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	11,671	0	11,671	54.02
54.03 03630	ULTRA SOUND	0	0	0	0	54.03
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00 05700	CT SCAN	0	5,706	0	5,706	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	10,387	0	10,387	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	88,663	0	88,663	59.00
60.00 06000	LABORATORY	0	129,899	0	129,899	60.00
65.00 06500	RESPIRATORY THERAPY	0	73,917	0	73,917	65.00
66.00 06600	PHYSICAL THERAPY	0	100,697	0	100,697	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	47,376	0	47,376	67.00
68.00 06800	SPEECH PATHOLOGY	0	16,134	0	16,134	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	120,579	0	120,579	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
76.00 03190	CHEMOTHERAPY	0	0	0	0	76.00
76.01 03020	WOUND CARE	0	32,102	0	32,102	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	ANDERSON OUTPATIENT CENTER	0	36,244	0	36,244	90.01
90.02 04950	DIABETIC EDUCATION	0	0	0	0	90.02
90.03 09002	MS CLINIC	0	0	0	0	90.03
91.00 09100	EMERGENCY	0	234,396	0	234,396	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	2,135,369	4,678,238	0	6,813,607	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	19,489	0	19,489	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	18,940	0	18,940	192.00
194.00 07950	FOUNDATION	0	6,586	0	6,586	194.00
194.01 07951	CHILDRENS CLINIC	0	0	0	0	194.01
194.02 07952	PSS ADMINISTRATION	0	0	0	0	194.02
194.03 07953	SEXUAL ASSAULT PROGRAM	0	0	0	0	194.03
194.04 07954	ASPR BIOTERRORISM GRANT	0	0	0	0	194.04
194.05 07955	HEALTHY FAMILIES	0	104,497	0	104,497	194.05
194.06 07956	DME-HOME CARE	0	0	0	0	194.06
194.07 07957	MARKETING	0	0	0	0	194.07
194.08 07958	CORPORATE COMMUNICATIONS	0	26,168	0	26,168	194.08

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet B
Part II
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	BLDG & FIXT-MAB			
		1.00	1.01			
	0			2A	4.00	
194.09 07959 MOB	0	0	0	0	0	194.09
194.10 07960 ASC	0	0	0	0	0	194.10
194.11 07961 MAB	0	0	0	0	0	194.11
194.12 07963 ADOLESCENT RESIDENTIAL SERVICES	0	29,461	0	29,461	972	194.12
194.13 07962 IDLE SPACE	0	0	0	0	0	194.13
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)	2,135,369	4,883,379	0	7,018,748	64,131	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

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Part II
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MAB					1.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,674,774				5.00
7.00	00700	OPERATION OF PLANT	124,992	702,280			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,274	1,317	15,540		8.00
9.00	00900	HOUSEKEEPING	63,519	19,585	0	186,420	9.00
10.00	01000	DIETARY	16,338	19,314	0	5,284	142,823
11.00	01100	CAFETERIA	45,982	35,326	0	9,665	0
13.00	01300	NURSING ADMINISTRATION	66,165	9,587	0	2,623	0
14.00	01400	CENTRAL SERVICES & SUPPLY	5,273	31,133	0	8,518	0
15.00	01500	PHARMACY	92,659	9,460	0	2,588	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,163	10,235	0	2,800	0
23.00	02300	ALLIED HEALTH-EMS	0	0	0	0	0
23.01	02301	ALLIED HEALTH-RAD TECH	3,015	216	0	59	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	389,818	132,040	11,252	36,125	115,857
31.00	03100	INTENSIVE CARE UNIT	119,881	28,777	2,287	7,873	9,657
41.00	04100	SUBPROVIDER - IRF	39,263	19,630	1,515	5,371	12,182
43.00	04300	NURSERY	6,596	10,932	305	2,991	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	252,791	94,218	0	25,777	17
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,683	41,519	0	11,359	1,870
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	75,912	28,028	0	7,668	0
54.01	03440	MAMMOGRAPHY	17,086	0	0	0	0
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	19,490	2,212	0	605	0
54.03	03630	ULTRA SOUND	10,131	0	0	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC	49,289	0	0	0	0
57.00	05700	CT SCAN	19,305	1,082	0	296	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11,535	1,969	0	539	0
59.00	05900	CARDIAC CATHETERIZATION	28,167	16,807	0	4,598	1,092
60.00	06000	LABORATORY	150,125	24,624	0	6,737	0
65.00	06500	RESPIRATORY THERAPY	36,264	14,012	0	3,834	0
66.00	06600	PHYSICAL THERAPY	64,189	19,088	0	5,222	0
67.00	06700	OCCUPATIONAL THERAPY	28,954	8,981	0	2,457	0
68.00	06800	SPEECH PATHOLOGY	9,863	3,058	0	837	0
69.00	06900	ELECTROCARDIOLOGY	4,752	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	9,590	22,857	0	6,254	24
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	80,320	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	114,272	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	335,061	0	0	0	0
76.00	03190	CHEMOTHERAPY	23,403	0	0	0	1,397
76.01	03020	WOUND CARE	21,630	6,085	0	1,665	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	ANDERSON OUTPATIENT CENTER	32,284	6,870	0	1,880	0
90.02	04950	DIABETIC EDUCATION	0	0	0	0	0
90.03	09002	MS CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	148,065	44,432	181	12,156	727
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,554,099	663,394	15,540	175,781	142,823
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	420	3,694	0	1,011	0
191.00	19100	RESEARCH	2,699	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	80,379	3,590	0	982	0
194.00	07950	FOUNDATION	142	1,248	0	342	0
194.01	07951	CHILDRENS CLINIC	0	0	0	0	0
194.02	07952	PSS ADMINISTRATION	1,357	0	0	0	0
194.03	07953	SEXUAL ASSAULT PROGRAM	149	0	0	0	0
194.04	07954	ASPR BIOTERRORISM GRANT	9	0	0	0	0
194.05	07955	HEALTHY FAMILIES	14,500	19,809	0	5,419	0
194.06	07956	DME-HOME CARE	59	0	0	0	0
194.07	07957	MARKETING	0	0	0	0	0
194.08	07958	CORPORATE COMMUNICATIONS	563	4,960	0	1,357	0
194.09	07959	MOB	8	0	0	0	0
194.10	07960	ASC	4	0	0	0	0
194.11	07961	MAB	0	0	0	0	0
194.12	07963	ADOLESCENT RESIDENTIAL SERVICES	20,386	5,585	0	1,528	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet B
Part II
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
194.13	07962 IDLE SPACE	0	0	0	0	0	194.13
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)	2,674,774	702,280	15,540	186,420	142,823	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet B
Part II
Date/Time Prepared:
11/22/2023 10:37 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	277,330					11.00
13.00	01300	13,747	145,270				13.00
14.00	01400	4,810	0	214,509			14.00
15.00	01500	18,985	0	2,658	180,571		15.00
16.00	01600	0	0	1	0	68,192	16.00
23.00	02300	0	0	0	0	0	23.00
23.01	02301	905	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	83,843	68,102	8,372	0	5,121	30.00
31.00	03100	21,642	23,185	5,292	0	2,003	31.00
41.00	04100	8,749	7,391	344	0	498	41.00
43.00	04300	1,105	1,280	189	0	116	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	13,363	15,044	162,475	0	13,752	50.00
52.00	05200	5,634	5,918	875	0	388	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	17,644	0	7,044	0	1,588	54.00
54.01	03440	2,005	0	911	0	461	54.01
54.02	03450	1,774	0	3,814	0	1,583	54.02
54.03	03630	2,285	0	115	0	821	54.03
55.00	05500	7,725	0	383	0	3,279	55.00
57.00	05700	4,872	0	90	0	1,666	57.00
58.00	05800	1,807	0	20	0	261	58.00
59.00	05900	6,006	3,756	3,740	0	2,379	59.00
60.00	06000	0	0	46	0	8,453	60.00
65.00	06500	8,523	0	2,603	0	1,777	65.00
66.00	06600	2,211	0	706	0	871	66.00
67.00	06700	1,129	0	332	0	402	67.00
68.00	06800	384	0	113	0	137	68.00
69.00	06900	1,135	0	30	0	129	69.00
70.00	07000	676	0	112	0	396	70.00
71.00	07100	0	0	0	0	1,960	71.00
72.00	07200	0	0	0	0	2,103	72.00
73.00	07300	0	0	0	180,571	8,518	73.00
76.00	03190	6,547	0	1,629	0	733	76.00
76.01	03020	3,529	0	5,309	0	554	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	3,147	0	17	0	423	90.01
90.02	04950	0	0	0	0	0	90.02
90.03	09002	0	0	0	0	0	90.03
91.00	09100	25,753	20,594	7,282	0	7,820	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		269,935	145,270	214,502	180,571	68,192	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	649	0	0	0	0	191.00
192.00	19200	1,316	0	2	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	847	0	0	0	0	194.02
194.03	07953	38	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	4,545	0	0	0	0	194.05
194.06	07956	0	0	5	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	0	0	0	194.09
194.10	07960	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet B
Part II
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11/22/2023 10:37 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		11.00	13.00	14.00	15.00	16.00		
194.12	07963	ADOLESCENT RESIDENTIAL SERVICES	0	0	0	0	0	194.12
194.13	07962	IDLE SPACE	0	0	0	0	0	194.13
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)	277,330	145,270	214,509	180,571	68,192	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet B Part II Date/Time Prepared: 11/22/2023 10:37 am
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Cost Center Description			ALLIED HEALTH-EMS	ALLIED HEALTH-RAD TECH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.00	23.01	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MAB						1.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
23.00	02300	ALLIED HEALTH-EMS	0					23.00
23.01	02301	ALLIED HEALTH-RAD TECH		5,490				23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS			1,564,117	0	1,564,117	30.00
31.00	03100	INTENSIVE CARE UNIT			377,477	0	377,477	31.00
41.00	04100	SUBPROVIDER - IRF			200,221	0	200,221	41.00
43.00	04300	NURSERY			81,426	0	81,426	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM			1,077,942	0	1,077,942	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM			317,407	0	317,407	52.00
53.00	05300	ANESTHESIOLOGY			0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			288,567	0	288,567	54.00
54.01	03440	MAMMOGRAPHY			20,879	0	20,879	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC			41,560	0	41,560	54.02
54.03	03630	ULTRA SOUND			13,804	0	13,804	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC			62,027	0	62,027	55.00
57.00	05700	CT SCAN			33,970	0	33,970	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)			26,889	0	26,889	58.00
59.00	05900	CARDIAC CATHETERIZATION			156,343	0	156,343	59.00
60.00	06000	LABORATORY			319,884	0	319,884	60.00
65.00	06500	RESPIRATORY THERAPY			142,616	0	142,616	65.00
66.00	06600	PHYSICAL THERAPY			193,538	0	193,538	66.00
67.00	06700	OCCUPATIONAL THERAPY			89,817	0	89,817	67.00
68.00	06800	SPEECH PATHOLOGY			30,590	0	30,590	68.00
69.00	06900	ELECTROCARDIOLOGY			6,231	0	6,231	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY			160,804	0	160,804	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS			82,280	0	82,280	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS			116,375	0	116,375	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS			524,150	0	524,150	73.00
76.00	03190	CHEMOTHERAPY			34,738	0	34,738	76.00
76.01	03020	WOUND CARE			71,445	0	71,445	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC			0	0	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER			82,542	0	82,542	90.01
90.02	04950	DIABETIC EDUCATION			0	0	0	90.02
90.03	09002	MS CLINIC			0	0	0	90.03
91.00	09100	EMERGENCY			507,254	0	507,254	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES			0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	6,624,893	0	6,624,893	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN			24,614	0	24,614	190.00
191.00	19100	RESEARCH			3,466	0	3,466	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES			109,152	0	109,152	192.00
194.00	07950	FOUNDATION			8,318	0	8,318	194.00
194.01	07951	CHILDRENS CLINIC			0	0	0	194.01
194.02	07952	PSS ADMINISTRATION			2,266	0	2,266	194.02
194.03	07953	SEXUAL ASSAULT PROGRAM			195	0	195	194.03
194.04	07954	ASPR BIOTERRORISM GRANT			9	0	9	194.04
194.05	07955	HEALTHY FAMILIES			149,289	0	149,289	194.05
194.06	07956	DME-HOME CARE			64	0	64	194.06
194.07	07957	MARKETING			0	0	0	194.07
194.08	07958	CORPORATE COMMUNICATIONS			33,048	0	33,048	194.08
194.09	07959	MOB			8	0	8	194.09

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			ALLIED HEALTH-EMS	ALLIED HEALTH-RAD TECH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.00	23.01	24.00	25.00	26.00	
194.10	07960	ASC			4	0	4	194.10
194.11	07961	MAB			0	0	0	194.11
194.12	07963	ADOLESCENT RESIDENTIAL SERVICES			57,932	0	57,932	194.12
194.13	07962	IDLE SPACE			0	0	0	194.13
200.00		Cross Foot Adjustments	0	5,490	5,490	0	5,490	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	5,490	7,018,748	0	7,018,748	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet B-1
Date/Time Prepared:
11/22/2023 10:37 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	BLDG & FIXT-MAB (SQUARE FEET)				
	1.00	1.01				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	471,575				1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT-MAB	0	0			1.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	6,193	0	45,655,215		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	51,875	0	1,576,174	-38,503,856	124,258,872 5.00
7.00 00700	OPERATION OF PLANT	55,747	0	1,624	0	5,806,548 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	671	0	0	0	337,916 8.00
9.00 00900	HOUSEKEEPING	9,977	0	0	0	2,950,797 9.00
10.00 01000	DIETARY	9,839	0	0	0	758,974 10.00
11.00 01100	CAFETERIA	17,996	0	0	0	2,136,096 11.00
13.00 01300	NURSING ADMINISTRATION	4,884	0	1,830,420	0	3,073,713 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	15,860	0	382,265	0	244,951 14.00
15.00 01500	PHARMACY	4,819	0	3,073,215	0	4,304,510 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	5,214	0	0	0	54,027 16.00
23.00 02300	ALLIED HEALTH-EMS	0	0	0	0	0 23.00
23.01 02301	ALLIED HEALTH-RAD TECH	110	0	110,761	0	140,081 23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	67,264	0	12,135,375	0	18,110,108 30.00
31.00 03100	INTENSIVE CARE UNIT	14,660	0	3,607,888	0	5,569,121 31.00
41.00 04100	SUBPROVIDER - IRF	10,000	0	1,226,236	0	1,824,003 41.00
43.00 04300	NURSERY	5,569	0	172,264	0	306,431 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	47,997	0	2,472,256	0	11,743,503 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	21,151	0	806,613	0	1,378,956 52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	14,278	0	2,012,843	0	3,526,540 54.00
54.01 03440	MAMMOGRAPHY	0	0	296,071	0	793,740 54.01
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	1,127	0	292,852	0	905,435 54.02
54.03 03630	ULTRA SOUND	0	0	321,437	0	470,650 54.03
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	961,700	0	2,289,739 55.00
57.00 05700	CT SCAN	551	0	678,005	0	896,818 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,003	0	264,339	0	535,884 58.00
59.00 05900	CARDIAC CATHETERIZATION	8,562	0	807,735	0	1,308,503 59.00
60.00 06000	LABORATORY	12,544	0	0	0	6,974,133 60.00
65.00 06500	RESPIRATORY THERAPY	7,138	0	1,199,800	0	1,684,644 65.00
66.00 06600	PHYSICAL THERAPY	9,724	0	394,558	0	2,981,919 66.00
67.00 06700	OCCUPATIONAL THERAPY	4,575	0	132,717	0	1,345,083 67.00
68.00 06800	SPEECH PATHOLOGY	1,558	0	45,211	0	458,204 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	131,867	0	220,750 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	11,644	0	225,024	0	445,494 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,731,323 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,308,565 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	15,565,392 73.00
76.00 03190	CHEMOTHERAPY	0	0	732,516	0	1,087,194 76.00
76.01 03020	WOUND CARE	3,100	0	406,747	0	1,004,822 76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0 90.00
90.01 09001	ANDERSON OUTPATIENT CENTER	3,500	0	1,193,272	0	1,499,759 90.01
90.02 04950	DIABETIC EDUCATION	0	0	0	0	0 90.02
90.03 09002	MS CLINIC	0	0	0	0	0 90.03
91.00 09100	EMERGENCY	22,635	0	4,162,394	0	6,878,434 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	451,765	0	41,654,179	-38,503,856	118,652,760 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,882	0	0	0	19,489 190.00
191.00 19100	RESEARCH	0	0	83,721	0	125,387 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,829	0	2,806,331	0	3,734,056 192.00
194.00 07950	FOUNDATION	636	0	0	0	6,586 194.00
194.01 07951	CHILDRENS CLINIC	0	0	0	0	0 194.01
194.02 07952	PSS ADMINISTRATION	0	0	44,275	0	63,063 194.02
194.03 07953	SEXUAL ASSAULT PROGRAM	0	0	5,528	0	6,944 194.03
194.04 07954	ASPR BIOTERRORISM GRANT	0	0	0	0	440 194.04
194.05 07955	HEALTHY FAMILIES	10,091	0	369,064	0	673,625 194.05
194.06 07956	DME-HOME CARE	0	0	0	0	2,747 194.06
194.07 07957	MARKETING	0	0	0	0	0 194.07

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet B-1
Date/Time Prepared:
11/22/2023 10:37 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	BLDG & FIXT-MAB (SQUARE FEET)					
	1.00	1.01	4.00				
194.08 07958 CORPORATE COMMUNICATIONS	2,527	0	0	0	0	26,168	194.08
194.09 07959 MOB	0	0	0	0	0	369	194.09
194.10 07960 ASC	0	0	0	154	0	193	194.10
194.11 07961 MAB	0	0	0	0	0	0	194.11
194.12 07963 ADOLESCENT RESIDENTIAL SERVICES	2,845	0	691,963	0	0	947,045	194.12
194.13 07962 IDLE SPACE	0	0	0	0	0	0	194.13
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)	4,883,379	0	8,388,058			38,503,856	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	10.355466	0.000000	0.183726			0.309868	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			64,131			2,674,774	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.001405			0.021526	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: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet B-1

Date/Time Prepared:
11/22/2023 10:37 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (TOTAL HOURS)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MAB					1.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	357,760				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	671	27,455			8.00
9.00	00900	HOUSEKEEPING	9,977	0	347,112		9.00
10.00	01000	DIETARY	9,839	0	9,839	101,203	10.00
11.00	01100	CAFETERIA	17,996	0	17,996	0	890,842
13.00	01300	NURSING ADMINISTRATION	4,884	0	4,884	0	44,159
14.00	01400	CENTRAL SERVICES & SUPPLY	15,860	0	15,860	0	15,451
15.00	01500	PHARMACY	4,819	0	4,819	0	60,984
16.00	01600	MEDICAL RECORDS & LIBRARY	5,214	0	5,214	0	0
23.00	02300	ALLIED HEALTH-EMS	0	0	0	0	0
23.01	02301	ALLIED HEALTH-RAD TECH	110	0	110	0	2,908
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	67,264	19,880	67,264	82,095	269,317
31.00	03100	INTENSIVE CARE UNIT	14,660	4,041	14,660	6,843	69,518
41.00	04100	SUBPROVIDER - IRF	10,000	2,677	10,000	8,632	28,105
43.00	04300	NURSERY	5,569	538	5,569	0	3,550
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	47,997	0	47,997	12	42,924
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,151	0	21,151	1,325	18,097
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,278	0	14,278	0	56,677
54.01	03440	MAMMOGRAPHY	0	0	0	0	6,439
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	1,127	0	1,127	0	5,699
54.03	03630	ULTRA SOUND	0	0	0	0	7,339
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	24,815
57.00	05700	CT SCAN	551	0	551	0	15,651
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,003	0	1,003	0	5,803
59.00	05900	CARDIAC CATHETERIZATION	8,562	0	8,562	774	19,292
60.00	06000	LABORATORY	12,544	0	12,544	0	0
65.00	06500	RESPIRATORY THERAPY	7,138	0	7,138	0	27,379
66.00	06600	PHYSICAL THERAPY	9,724	0	9,724	0	7,103
67.00	06700	OCCUPATIONAL THERAPY	4,575	0	4,575	0	3,625
68.00	06800	SPEECH PATHOLOGY	1,558	0	1,558	0	1,235
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	3,645
70.00	07000	ELECTROENCEPHALOGRAPHY	11,644	0	11,644	17	2,170
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03190	CHEMOTHERAPY	0	0	0	990	21,030
76.01	03020	WOUND CARE	3,100	0	3,100	0	11,336
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	ANDERSON OUTPATIENT CENTER	3,500	0	3,500	0	10,110
90.02	04950	DIABETIC EDUCATION	0	0	0	0	0
90.03	09002	MS CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	22,635	319	22,635	515	82,725
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	337,950	27,455	327,302	101,203	867,086
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,882	0	1,882	0	0
191.00	19100	RESEARCH	0	0	0	0	2,086
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,829	0	1,829	0	4,227
194.00	07950	FOUNDATION	636	0	636	0	0
194.01	07951	CHILDRENS CLINIC	0	0	0	0	0
194.02	07952	PSS ADMINISTRATION	0	0	0	0	2,722
194.03	07953	SEXUAL ASSAULT PROGRAM	0	0	0	0	121
194.04	07954	ASPR BIOTERRORISM GRANT	0	0	0	0	0
194.05	07955	HEALTHY FAMILIES	10,091	0	10,091	0	14,600
194.06	07956	DME-HOME CARE	0	0	0	0	0
194.07	07957	MARKETING	0	0	0	0	0
194.08	07958	CORPORATE COMMUNICATIONS	2,527	0	2,527	0	0
194.09	07959	MOB	0	0	0	0	0
194.10	07960	ASC	0	0	0	0	0
194.11	07961	MAB	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet B-1

Date/Time Prepared:
11/22/2023 10:37 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (TOTAL HOURS)	
		7.00	8.00	9.00	10.00	11.00	
194.12	07963 ADOLESCENT RESIDENTIAL SERVICES	2,845	0	2,845	0	0	194.12
194.13	07962 IDLE SPACE	0	0	0	0	0	194.13
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)	7,605,811	456,890	4,077,261	1,318,900	3,391,976	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	21.259534	16.641413	11.746240	13.032222	3.807607	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	702,280	15,540	186,420	142,823	277,330	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	1.962992	0.566017	0.537060	1.411253	0.311312	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: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	ALLIED HEALTH-EMS (ASSIGNED TIME)	
		13.00	14.00	15.00	16.00	23.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	379,619					13.00
14.00	01400	0	11,883,221				14.00
15.00	01500	0	147,226	15,565,392			15.00
16.00	01600	0	36	0	712,345,517		16.00
23.00	02300	0	0	0	0	0	23.00
23.01	02301	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	177,963	463,805	0	53,346,238	0	30.00
31.00	03100	60,588	293,145	0	20,865,195	0	31.00
41.00	04100	19,313	19,073	0	5,184,091	0	41.00
43.00	04300	3,346	10,483	0	1,206,042	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	39,312	9,000,554	0	145,248,212	0	50.00
52.00	05200	15,464	48,449	0	4,045,591	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	390,228	0	16,542,312	0	54.00
54.01	03440	0	50,467	0	4,801,889	0	54.01
54.02	03450	0	211,269	0	16,492,297	0	54.02
54.03	03630	0	6,353	0	8,548,512	0	54.03
55.00	05500	0	21,231	0	34,157,489	0	55.00
57.00	05700	0	5,001	0	17,355,972	0	57.00
58.00	05800	0	1,092	0	2,718,591	0	58.00
59.00	05900	9,816	207,193	0	24,784,796	0	59.00
60.00	06000	0	2,574	0	88,047,756	0	60.00
65.00	06500	0	144,191	0	18,511,838	0	65.00
66.00	06600	0	39,133	0	9,069,180	0	66.00
67.00	06700	0	18,410	0	4,191,817	0	67.00
68.00	06800	0	6,271	0	1,427,964	0	68.00
69.00	06900	0	1,667	0	1,346,819	0	69.00
70.00	07000	0	6,215	0	4,124,274	0	70.00
71.00	07100	0	0	0	20,419,563	0	71.00
72.00	07200	0	0	0	21,901,581	0	72.00
73.00	07300	0	0	15,565,392	88,730,029	0	73.00
76.00	03190	0	90,262	0	7,631,560	0	76.00
76.01	03020	0	294,091	0	5,774,267	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	937	0	4,410,152	0	90.01
90.02	04950	0	0	0	0	0	90.02
90.03	09002	0	0	0	0	0	90.03
91.00	09100	53,817	403,438	0	81,461,490	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		379,619	11,882,794	15,565,392	712,345,517	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	124	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	303	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	0	0	0	194.09

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	ALLIED HEALTH-EMS (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	23.00	
194.10	07960	ASC	0	0	0	0	0	194.10
194.11	07961	MAB	0	0	0	0	0	194.11
194.12	07963	ADOLESCENT RESIDENTIAL SERVICES	0	0	0	0	0	194.12
194.13	07962	IDLE SPACE	0	0	0	0	0	194.13
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)	4,355,499	903,155	6,040,788	242,863	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.473343	0.076003	0.388091	0.000341	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	145,270	214,509	180,571	68,192	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.382673	0.018051	0.011601	0.000096	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: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet B-1 Date/Time Prepared: 11/22/2023 10:37 am
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Cost Center Description		ALLIED HEALTH-RAD TECH (ASSIGNED TIME) 23.01	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MAB	1.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
23.00	02300	ALLIED HEALTH-EMS	23.00
23.01	02301	ALLIED HEALTH-RAD TECH	23.01
		100,617,061	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03440	MAMMOGRAPHY	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	54.02
54.03	03630	ULTRA SOUND	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
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
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
76.00	03190	CHEMOTHERAPY	76.00
76.01	03020	WOUND CARE	76.01
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	90.01
90.02	04950	DIABETIC EDUCATION	90.02
90.03	09002	MS CLINIC	90.03
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		100,617,061	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	FOUNDATION	194.00
194.01	07951	CHILDRENS CLINIC	194.01
194.02	07952	PSS ADMINISTRATION	194.02
194.03	07953	SEXUAL ASSAULT PROGRAM	194.03
194.04	07954	ASPR BIOTERRORISM GRANT	194.04
194.05	07955	HEALTHY FAMILIES	194.05
194.06	07956	DME-HOME CARE	194.06
194.07	07957	MARKETING	194.07
194.08	07958	CORPORATE COMMUNICATIONS	194.08
194.09	07959	MOB	194.09

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0088

Period:
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To 06/30/2023

Worksheet B-1
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Cost Center Description			ALLIED HEALTH-RAD TECH (ASSIGNED TIME) 23.01	
194.10	07960	ASC	0	194.10
194.11	07961	MAB	0	194.11
194.12	07963	ADOLESCENT RESIDENTIAL SERVICES	0	194.12
194.13	07962	IDLE SPACE	0	194.13
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)	198,192	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001970	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,490	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000055	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

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0088		Period: From 07/01/2022 To 06/30/2023		Worksheet C Part I Date/Time Prepared: 11/22/2023 10:37 am		
		Title XVIII		Hospital		PPS		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	30,463,399		30,463,399	0	30,463,399	30.00
31.00	03100	INTENSIVE CARE UNIT	8,924,344		8,924,344	0	8,924,344	31.00
41.00	04100	SUBPROVIDER - IRF	3,208,119		3,208,119	0	3,208,119	41.00
43.00	04300	NURSERY	647,261		647,261	0	647,261	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	18,314,798		18,314,798	0	18,314,798	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,773,015		2,773,015	0	2,773,015	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,374,250		5,374,250	0	5,374,250	54.00
54.01	03440	MAMMOGRAPHY	1,079,145		1,079,145	0	1,079,145	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	1,299,068		1,299,068	0	1,299,068	54.02
54.03	03630	ULTRA SOUND	664,672		664,672	0	664,672	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	3,174,270		3,174,270	0	3,174,270	55.00
57.00	05700	CT SCAN	1,292,981		1,292,981	0	1,292,981	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	763,503		763,503	0	763,503	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,216,925		2,216,925	0	2,216,925	59.00
60.00	06000	LABORATORY	9,579,439		9,579,439	0	9,579,439	60.00
65.00	06500	RESPIRATORY THERAPY	2,563,777	0	2,563,777	0	2,563,777	65.00
66.00	06600	PHYSICAL THERAPY	4,259,980	0	4,259,980	0	4,259,980	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,929,513	0	1,929,513	0	1,929,513	67.00
68.00	06800	SPEECH PATHOLOGY	657,276	0	657,276	0	657,276	68.00
69.00	06900	ELECTROCARDIOLOGY	303,618		303,618	0	303,618	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	978,220		978,220	0	978,220	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,894,504		4,894,504	0	4,894,504	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,960,987		6,960,987	0	6,960,987	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,459,654		26,459,654	0	26,459,654	73.00
76.00	03190	CHEMOTHERAPY	1,526,519		1,526,519	0	1,526,519	76.00
76.01	03020	WOUND CARE	1,485,986		1,485,986	0	1,485,986	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	2,120,076		2,120,076	0	2,120,076	90.01
90.02	04950	DIABETIC EDUCATION	0		0	0	0	90.02
90.03	09002	MS CLINIC	0		0	0	0	90.03
91.00	09100	EMERGENCY	10,759,833		10,759,833	0	10,759,833	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,855,164		2,855,164	0	2,855,164	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	157,530,296	0	157,530,296	0	157,530,296	200.00
201.00		Less observation Beds	2,855,164		2,855,164		2,855,164	201.00
202.00		Total (see instructions)	154,675,132	0	154,675,132	0	154,675,132	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0088		Period: From 07/01/2022 To 06/30/2023		Worksheet C Part I Date/Time Prepared: 11/22/2023 10:37 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	49,176,044		49,176,044				30.00
31.00	03100	INTENSIVE CARE UNIT	20,865,195		20,865,195				31.00
41.00	04100	SUBPROVIDER - IRF	5,184,091		5,184,091				41.00
43.00	04300	NURSERY	1,206,042		1,206,042				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	26,040,459	119,207,753	145,248,212	0.126093	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,616,560	429,031	4,045,591	0.685441	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,047,622	10,494,690	16,542,312	0.324879	0.000000		54.00
54.01	03440	MAMMOGRAPHY	2,369	4,799,520	4,801,889	0.224733	0.000000		54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	1,318,365	15,173,932	16,492,297	0.078768	0.000000		54.02
54.03	03630	ULTRA SOUND	1,492,371	7,056,141	8,548,512	0.077753	0.000000		54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	406,555	33,750,934	34,157,489	0.092930	0.000000		55.00
57.00	05700	CT SCAN	3,931,629	13,424,343	17,355,972	0.074498	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	603,423	2,115,168	2,718,591	0.280845	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	6,348,649	18,436,147	24,784,796	0.089447	0.000000		59.00
60.00	06000	LABORATORY	32,553,389	55,494,367	88,047,756	0.108798	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	15,563,418	2,948,420	18,511,838	0.138494	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	3,001,887	6,067,293	9,069,180	0.469721	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,265,814	1,926,003	4,191,817	0.460305	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	789,588	638,376	1,427,964	0.460289	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,346,819	1,346,819	0.225433	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	212,933	3,911,341	4,124,274	0.237186	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,352,424	11,067,139	20,419,563	0.239697	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,286,054	17,615,527	21,901,581	0.317830	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,742,500	65,987,529	88,730,029	0.298204	0.000000		73.00
76.00	03190	CHEMOTHERAPY	67,275	7,564,285	7,631,560	0.200027	0.000000		76.00
76.01	03020	WOUND CARE	77,258	5,697,009	5,774,267	0.257346	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0.000000	0.000000		90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	8,464	4,401,688	4,410,152	0.480726	0.000000		90.01
90.02	04950	DIABETIC EDUCATION	0	0	0	0.000000	0.000000		90.02
90.03	09002	MS CLINIC	0	0	0	0.000000	0.000000		90.03
91.00	09100	EMERGENCY	18,152,585	63,308,905	81,461,490	0.132085	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,327,555	2,842,639	4,170,194	0.684660	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000		95.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	236,640,518	475,704,999	712,345,517				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	236,640,518	475,704,999	712,345,517				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Prepared: 11/22/2023 10:37 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.126093	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.685441	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.324879	54.00
54.01	03440	MAMMOGRAPHY	0.224733	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.078768	54.02
54.03	03630	ULTRA SOUND	0.077753	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0.092930	55.00
57.00	05700	CT SCAN	0.074498	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.280845	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.089447	59.00
60.00	06000	LABORATORY	0.108798	60.00
65.00	06500	RESPIRATORY THERAPY	0.138494	65.00
66.00	06600	PHYSICAL THERAPY	0.469721	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.460305	67.00
68.00	06800	SPEECH PATHOLOGY	0.460289	68.00
69.00	06900	ELECTROCARDIOLOGY	0.225433	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.237186	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.239697	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.317830	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.298204	73.00
76.00	03190	CHEMOTHERAPY	0.200027	76.00
76.01	03020	WOUND CARE	0.257346	76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	0.480726	90.01
90.02	04950	DIABETIC EDUCATION	0.000000	90.02
90.03	09002	MS CLINIC	0.000000	90.03
91.00	09100	EMERGENCY	0.132085	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.684660	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0088		Period: From 07/01/2022 To 06/30/2023		Worksheet C Part I Date/Time Prepared: 11/22/2023 10:37 am		
		Title XIX		Hospital		Cost		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	30,463,399		30,463,399	0	30,463,399	30.00
31.00	03100	INTENSIVE CARE UNIT	8,924,344		8,924,344	0	8,924,344	31.00
41.00	04100	SUBPROVIDER - IRF	3,208,119		3,208,119	0	3,208,119	41.00
43.00	04300	NURSERY	647,261		647,261	0	647,261	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	18,314,798		18,314,798	0	18,314,798	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,773,015		2,773,015	0	2,773,015	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,374,250		5,374,250	0	5,374,250	54.00
54.01	03440	MAMMOGRAPHY	1,079,145		1,079,145	0	1,079,145	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	1,299,068		1,299,068	0	1,299,068	54.02
54.03	03630	ULTRA SOUND	664,672		664,672	0	664,672	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	3,174,270		3,174,270	0	3,174,270	55.00
57.00	05700	CT SCAN	1,292,981		1,292,981	0	1,292,981	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	763,503		763,503	0	763,503	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,216,925		2,216,925	0	2,216,925	59.00
60.00	06000	LABORATORY	9,579,439		9,579,439	0	9,579,439	60.00
65.00	06500	RESPIRATORY THERAPY	2,563,777	0	2,563,777	0	2,563,777	65.00
66.00	06600	PHYSICAL THERAPY	4,259,980	0	4,259,980	0	4,259,980	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,929,513	0	1,929,513	0	1,929,513	67.00
68.00	06800	SPEECH PATHOLOGY	657,276	0	657,276	0	657,276	68.00
69.00	06900	ELECTROCARDIOLOGY	303,618		303,618	0	303,618	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	978,220		978,220	0	978,220	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,894,504		4,894,504	0	4,894,504	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,960,987		6,960,987	0	6,960,987	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,459,654		26,459,654	0	26,459,654	73.00
76.00	03190	CHEMOTHERAPY	1,526,519		1,526,519	0	1,526,519	76.00
76.01	03020	WOUND CARE	1,485,986		1,485,986	0	1,485,986	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	2,120,076		2,120,076	0	2,120,076	90.01
90.02	04950	DIABETIC EDUCATION	0		0	0	0	90.02
90.03	09002	MS CLINIC	0		0	0	0	90.03
91.00	09100	EMERGENCY	10,759,833		10,759,833	0	10,759,833	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,855,164		2,855,164	0	2,855,164	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	157,530,296	0	157,530,296	0	157,530,296	200.00
201.00		Less observation Beds	2,855,164		2,855,164		2,855,164	201.00
202.00		Total (see instructions)	154,675,132	0	154,675,132	0	154,675,132	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0088		Period: From 07/01/2022 To 06/30/2023		Worksheet C Part I Date/Time Prepared: 11/22/2023 10:37 am		
			Title XIX			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	49,176,044		49,176,044				30.00
31.00	03100	INTENSIVE CARE UNIT	20,865,195		20,865,195				31.00
41.00	04100	SUBPROVIDER - IRF	5,184,091		5,184,091				41.00
43.00	04300	NURSERY	1,206,042		1,206,042				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	26,040,459	119,207,753	145,248,212	0.126093	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,616,560	429,031	4,045,591	0.685441	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,047,622	10,494,690	16,542,312	0.324879	0.000000		54.00
54.01	03440	MAMMOGRAPHY	2,369	4,799,520	4,801,889	0.224733	0.000000		54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	1,318,365	15,173,932	16,492,297	0.078768	0.000000		54.02
54.03	03630	ULTRA SOUND	1,492,371	7,056,141	8,548,512	0.077753	0.000000		54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	406,555	33,750,934	34,157,489	0.092930	0.000000		55.00
57.00	05700	CT SCAN	3,931,629	13,424,343	17,355,972	0.074498	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	603,423	2,115,168	2,718,591	0.280845	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	6,348,649	18,436,147	24,784,796	0.089447	0.000000		59.00
60.00	06000	LABORATORY	32,553,389	55,494,367	88,047,756	0.108798	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	15,563,418	2,948,420	18,511,838	0.138494	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	3,001,887	6,067,293	9,069,180	0.469721	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,265,814	1,926,003	4,191,817	0.460305	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	789,588	638,376	1,427,964	0.460289	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,346,819	1,346,819	0.225433	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	212,933	3,911,341	4,124,274	0.237186	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,352,424	11,067,139	20,419,563	0.239697	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,286,054	17,615,527	21,901,581	0.317830	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,742,500	65,987,529	88,730,029	0.298204	0.000000		73.00
76.00	03190	CHEMOTHERAPY	67,275	7,564,285	7,631,560	0.200027	0.000000		76.00
76.01	03020	WOUND CARE	77,258	5,697,009	5,774,267	0.257346	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0.000000	0.000000		90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	8,464	4,401,688	4,410,152	0.480726	0.000000		90.01
90.02	04950	DIABETIC EDUCATION	0	0	0	0.000000	0.000000		90.02
90.03	09002	MS CLINIC	0	0	0	0.000000	0.000000		90.03
91.00	09100	EMERGENCY	18,152,585	63,308,905	81,461,490	0.132085	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,327,555	2,842,639	4,170,194	0.684660	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000		95.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	236,640,518	475,704,999	712,345,517				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	236,640,518	475,704,999	712,345,517				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Prepared: 11/22/2023 10:37 am
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	03440	MAMMOGRAPHY	0.000000	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.000000	54.02
54.03	03630	ULTRA SOUND	0.000000	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
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	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03190	CHEMOTHERAPY	0.000000	76.00
76.01	03020	WOUND CARE	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	0.000000	90.01
90.02	04950	DIABETIC EDUCATION	0.000000	90.02
90.03	09002	MS CLINIC	0.000000	90.03
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0088		Period: From 07/01/2022 To 06/30/2023		Worksheet D Part I Date/Time Prepared: 11/22/2023 10:37 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS 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	1,564,117	0	1,564,117	22,150	70.61	30.00
31.00	INTENSIVE CARE UNIT	377,477		377,477	4,041	93.41	31.00
41.00	SUBPROVIDER - IRF	200,221	0	200,221	2,677	74.79	41.00
43.00	NURSERY	81,426		81,426	547	148.86	43.00
200.00	Total (lines 30 through 199)	2,223,241		2,223,241	29,415		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	2,752	194,319				
31.00	INTENSIVE CARE UNIT	2,482	231,844				
41.00	SUBPROVIDER - IRF	1,122	83,914				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	6,356	510,077				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part II Date/Time Prepared: 11/22/2023 10:37 am
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Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,077,942	145,248,212	0.007421	8,305,997	61,639	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	317,407	4,045,591	0.078458	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	288,567	16,542,312	0.017444	1,231,223	21,477	54.00
54.01	03440	MAMMOGRAPHY	20,879	4,801,889	0.004348	0	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	41,560	16,492,297	0.002520	326,566	823	54.02
54.03	03630	ULTRA SOUND	13,804	8,548,512	0.001615	0	0	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	62,027	34,157,489	0.001816	130,356	237	55.00
57.00	05700	CT SCAN	33,970	17,355,972	0.001957	1,044,560	2,044	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	26,889	2,718,591	0.009891	133,000	1,316	58.00
59.00	05900	CARDIAC CATHETERIZATION	156,343	24,784,796	0.006308	1,561,918	9,853	59.00
60.00	06000	LABORATORY	319,884	88,047,756	0.003633	7,791,172	28,305	60.00
65.00	06500	RESPIRATORY THERAPY	142,616	18,511,838	0.007704	4,118,041	31,725	65.00
66.00	06600	PHYSICAL THERAPY	193,538	9,069,180	0.021340	554,542	11,834	66.00
67.00	06700	OCCUPATIONAL THERAPY	89,817	4,191,817	0.021427	363,487	7,788	67.00
68.00	06800	SPEECH PATHOLOGY	30,590	1,427,964	0.021422	180,410	3,865	68.00
69.00	06900	ELECTROCARDIOLOGY	6,231	1,346,819	0.004626	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	160,804	4,124,274	0.038990	97,667	3,808	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	82,280	20,419,563	0.004029	2,029,327	8,176	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	116,375	21,901,581	0.005314	2,211,208	11,750	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	524,150	88,730,029	0.005907	5,227,531	30,879	73.00
76.00	03190	CHEMOTHERAPY	34,738	7,631,560	0.004552	0	0	76.00
76.01	03020	WOUND CARE	71,445	5,774,267	0.012373	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	82,542	4,410,152	0.018716	0	0	90.01
90.02	04950	DIABETIC EDUCATION	0	0	0.000000	0	0	90.02
90.03	09002	MS CLINIC	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	507,254	81,461,490	0.006227	4,136,834	25,760	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	146,596	4,170,194	0.035153	613,262	21,558	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	4,548,248	635,914,145		40,057,101	282,837	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part III Date/Time Prepared: 11/22/2023 10:37 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	
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	22,150	0.00	2,752	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	4,041	0.00	2,482	31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	2,677	0.00	1,122	41.00	
43.00	04300	NURSERY	0	0	547	0.00	0	43.00	
200.00		Total (lines 30 through 199)	0	0	29,415	0.00	6,356	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Prepared: 11/22/2023 10:37 am
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Cost Center Description	Title XVIII			Hospital		Allied Health Post-Stepdown Adjustments	Allied Health PPS	
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program					
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	32,588	54.00
54.01	03440	MAMMOGRAPHY	0	0	0	0	9,460	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	32,490	54.02
54.03	03630	ULTRA SOUND	0	0	0	0	16,841	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	67,266	55.00
57.00	05700	CT SCAN	0	0	0	0	34,191	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	5,356	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
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03190	CHEMOTHERAPY	0	0	0	0	0	76.00
76.01	03020	WOUND CARE	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	0	0	0	0	0	90.01
90.02	04950	DIABETIC EDUCATION	0	0	0	0	0	90.02
90.03	09002	MS CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	198,192	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Prepared: 11/22/2023 10:37 am
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	145,248,212	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	4,045,591	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	32,588	32,588	16,542,312	0.001970	54.00
54.01 03440 MAMMOGRAPHY	0	9,460	9,460	4,801,889	0.001970	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	32,490	32,490	16,492,297	0.001970	54.02
54.03 03630 ULTRA SOUND	0	16,841	16,841	8,548,512	0.001970	54.03
55.00 05500 RADIOLOGY-THERAPEUTIC	0	67,266	67,266	34,157,489	0.001969	55.00
57.00 05700 CT SCAN	0	34,191	34,191	17,355,972	0.001970	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	5,356	5,356	2,718,591	0.001970	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	24,784,796	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	88,047,756	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	18,511,838	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	9,069,180	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	4,191,817	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	1,427,964	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	1,346,819	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	4,124,274	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	20,419,563	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,901,581	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	88,730,029	0.000000	73.00
76.00 03190 CHEMOTHERAPY	0	0	0	7,631,560	0.000000	76.00
76.01 03020 WOUND CARE	0	0	0	5,774,267	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0.000000	90.00
90.01 09001 ANDERSON OUTPATIENT CENTER	0	0	0	4,410,152	0.000000	90.01
90.02 04950 DIABETIC EDUCATION	0	0	0	0	0.000000	90.02
90.03 09002 MS CLINIC	0	0	0	0	0.000000	90.03
91.00 09100 EMERGENCY	0	0	0	81,461,490	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,170,194	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	198,192	198,192	635,914,145		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Prepared: 11/22/2023 10:37 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		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	8,305,997	0	24,602,340	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	403	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.001970	1,231,223	2,426	2,844,717	5,604	54.00
54.01	03440	MAMMOGRAPHY	0.001970	0	0	0	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.001970	326,566	643	3,915,909	7,714	54.02
54.03	03630	ULTRA SOUND	0.001970	0	0	0	0	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0.001969	130,356	257	7,833,302	15,424	55.00
57.00	05700	CT SCAN	0.001970	1,044,560	2,058	2,247,678	4,428	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.001970	133,000	262	379,650	748	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,561,918	0	3,379,992	0	59.00
60.00	06000	LABORATORY	0.000000	7,791,172	0	5,089,437	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,118,041	0	653,707	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	554,542	0	71,058	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	363,487	0	14,189	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	180,410	0	114,283	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	97,667	0	583,540	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,029,327	0	2,028,688	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,211,208	0	4,486,812	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,227,531	0	20,641,870	0	73.00
76.00	03190	CHEMOTHERAPY	0.000000	0	0	5,713	0	76.00
76.01	03020	WOUND CARE	0.000000	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	0.000000	0	0	153,566	0	90.01
90.02	04950	DIABETIC EDUCATION	0.000000	0	0	0	0	90.02
90.03	09002	MS CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	4,136,834	0	7,509,845	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	613,262	0	1,886,652	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		40,057,101	5,646	88,443,351	33,918	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part V Date/Time Prepared: 11/22/2023 10:37 am
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		Title XVIII		Hospital		PPS	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.126093	24,602,340	0	0	3,102,183	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.685441	403	0	0	276	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.324879	2,844,717	0	0	924,189	54.00
54.01	03440 MAMMOGRAPHY	0.224733	0	0	0	0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.078768	3,915,909	0	0	308,448	54.02
54.03	03630 ULTRA SOUND	0.077753	0	0	0	0	54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0.092930	7,833,302	0	0	727,949	55.00
57.00	05700 CT SCAN	0.074498	2,247,678	0	0	167,448	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.280845	379,650	0	0	106,623	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.089447	3,379,992	0	0	302,330	59.00
60.00	06000 LABORATORY	0.108798	5,089,437	0	0	553,721	60.00
65.00	06500 RESPIRATORY THERAPY	0.138494	653,707	0	0	90,534	65.00
66.00	06600 PHYSICAL THERAPY	0.469721	71,058	0	0	33,377	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.460305	14,189	0	0	6,531	67.00
68.00	06800 SPEECH PATHOLOGY	0.460289	114,283	0	0	52,603	68.00
69.00	06900 ELECTROCARDIOLOGY	0.225433	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.237186	583,540	0	0	138,408	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.239697	2,028,688	0	0	486,270	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.317830	4,486,812	0	0	1,426,043	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.298204	20,641,870	0	4,520	6,155,488	73.00
76.00	03190 CHEMOTHERAPY	0.200027	5,713	0	0	1,143	76.00
76.01	03020 WOUND CARE	0.257346	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	09001 ANDERSON OUTPATIENT CENTER	0.480726	153,566	0	0	73,823	90.01
90.02	04950 DIABETIC EDUCATION	0.000000	0	0	0	0	90.02
90.03	09002 MS CLINIC	0.000000	0	0	0	0	90.03
91.00	09100 EMERGENCY	0.132085	7,509,845	0	0	991,938	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.684660	1,886,652	0	0	1,291,715	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
200.00	Subtotal (see instructions)		88,443,351	0	4,520	16,941,040	200.00
201.00	Less PBP Clinic Lab. Services-Program Only charges			0	0	0	201.00
202.00	Net Charges (line 200 - line 201)		88,443,351	0	4,520	16,941,040	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part V Date/Time Prepared: 11/22/2023 10:37 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs		Hospital	PPS
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03440 MAMMOGRAPHY	0	0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	54.02
54.03	03630 ULTRA SOUND	0	0	54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
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
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	1,348	73.00
76.00	03190 CHEMOTHERAPY	0	0	76.00
76.01	03020 WOUND CARE	0	0	76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.01	09001 ANDERSON OUTPATIENT CENTER	0	0	90.01
90.02	04950 DIABETIC EDUCATION	0	0	90.02
90.03	09002 MS CLINIC	0	0	90.03
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
200.00	Subtotal (see instructions)	0	1,348	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00	Net Charges (line 200 - line 201)	0	1,348	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0088 Component CCN: 15-T088		Period: From 07/01/2022 To 06/30/2023		Worksheet D Part II Date/Time Prepared: 11/22/2023 10:37 am		
Title XVIII				Subprovider - IRF		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,077,942	145,248,212	0.007421	23,962	178	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	317,407	4,045,591	0.078458	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	288,567	16,542,312	0.017444	37,912	661	54.00
54.01	03440	MAMMOGRAPHY	20,879	4,801,889	0.004348	0	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	41,560	16,492,297	0.002520	3,887	10	54.02
54.03	03630	ULTRA SOUND	13,804	8,548,512	0.001615	0	0	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	62,027	34,157,489	0.001816	0	0	55.00
57.00	05700	CT SCAN	33,970	17,355,972	0.001957	18,140	35	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	26,889	2,718,591	0.009891	6,650	66	58.00
59.00	05900	CARDIAC CATHETERIZATION	156,343	24,784,796	0.006308	13,290	84	59.00
60.00	06000	LABORATORY	319,884	88,047,756	0.003633	411,960	1,497	60.00
65.00	06500	RESPIRATORY THERAPY	142,616	18,511,838	0.007704	213,913	1,648	65.00
66.00	06600	PHYSICAL THERAPY	193,538	9,069,180	0.021340	486,738	10,387	66.00
67.00	06700	OCCUPATIONAL THERAPY	89,817	4,191,817	0.021427	518,019	11,100	67.00
68.00	06800	SPEECH PATHOLOGY	30,590	1,427,964	0.021422	125,436	2,687	68.00
69.00	06900	ELECTROCARDIOLOGY	6,231	1,346,819	0.004626	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	160,804	4,124,274	0.038990	4,186	163	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	82,280	20,419,563	0.004029	111,289	448	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	116,375	21,901,581	0.005314	1,763	9	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	524,150	88,730,029	0.005907	228,085	1,347	73.00
76.00	03190	CHEMOTHERAPY	34,738	7,631,560	0.004552	0	0	76.00
76.01	03020	WOUND CARE	71,445	5,774,267	0.012373	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	82,542	4,410,152	0.018716	0	0	90.01
90.02	04950	DIABETIC EDUCATION	0	0	0.000000	0	0	90.02
90.03	09002	MS CLINIC	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	507,254	81,461,490	0.006227	31,946	199	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	4,170,194	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	4,401,652	635,914,145		2,237,176	30,519	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0088 Component CCN: 15-T088	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Prepared: 11/22/2023 10:37 am
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Cost Center Description		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
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	32,588	54.00
54.01	03440	MAMMOGRAPHY	0	0	0	9,460	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	32,490	54.02
54.03	03630	ULTRA SOUND	0	0	0	16,841	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	67,266	55.00
57.00	05700	CT SCAN	0	0	0	34,191	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	5,356	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
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
76.00	03190	CHEMOTHERAPY	0	0	0	0	76.00
76.01	03020	WOUND CARE	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	0	0	0	0	90.01
90.02	04950	DIABETIC EDUCATION	0	0	0	0	90.02
90.03	09002	MS CLINIC	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	198,192	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0088 Component CCN: 15-T088	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Prepared: 11/22/2023 10:37 am
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	145,248,212	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	4,045,591	0.000000	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	32,588	32,588	16,542,312	0.001970	54.00
54.01	03440 MAMMOGRAPHY	0	9,460	9,460	4,801,889	0.001970	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	32,490	32,490	16,492,297	0.001970	54.02
54.03	03630 ULTRA SOUND	0	16,841	16,841	8,548,512	0.001970	54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0	67,266	67,266	34,157,489	0.001969	55.00
57.00	05700 CT SCAN	0	34,191	34,191	17,355,972	0.001970	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	5,356	5,356	2,718,591	0.001970	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	24,784,796	0.000000	59.00
60.00	06000 LABORATORY	0	0	0	88,047,756	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	18,511,838	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	9,069,180	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	4,191,817	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	1,427,964	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	1,346,819	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	4,124,274	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	20,419,563	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,901,581	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	88,730,029	0.000000	73.00
76.00	03190 CHEMOTHERAPY	0	0	0	7,631,560	0.000000	76.00
76.01	03020 WOUND CARE	0	0	0	5,774,267	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0.000000	90.00
90.01	09001 ANDERSON OUTPATIENT CENTER	0	0	0	4,410,152	0.000000	90.01
90.02	04950 DIABETIC EDUCATION	0	0	0	0	0.000000	90.02
90.03	09002 MS CLINIC	0	0	0	0	0.000000	90.03
91.00	09100 EMERGENCY	0	0	0	81,461,490	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,170,194	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	0	198,192	198,192	635,914,145		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0088 Component CCN: 15-T088		Period: From 07/01/2022 To 06/30/2023		Worksheet D Part IV Date/Time Prepared: 11/22/2023 10:37 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	23,962	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.001970	37,912	75	0	54.00
54.01	03440	MAMMOGRAPHY	0.001970	0	0	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.001970	3,887	8	0	54.02
54.03	03630	ULTRA SOUND	0.001970	0	0	0	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0.001969	0	0	0	55.00
57.00	05700	CT SCAN	0.001970	18,140	36	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.001970	6,650	13	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	13,290	0	0	59.00
60.00	06000	LABORATORY	0.000000	411,960	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	213,913	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	486,738	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	518,019	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	125,436	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	4,186	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	111,289	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,763	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	228,085	0	0	73.00
76.00	03190	CHEMOTHERAPY	0.000000	0	0	0	76.00
76.01	03020	WOUND CARE	0.000000	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	0.000000	0	0	0	90.01
90.02	04950	DIABETIC EDUCATION	0.000000	0	0	0	90.02
90.03	09002	MS CLINIC	0.000000	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	31,946	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)		2,237,176	132	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part V Date/Time Prepared: 11/22/2023 10:37 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.)
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.126093	0	1,117,497	0	0 50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.685441	0	18,235	0	0 52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.324879	0	215,235	0	0 54.00
54.01 03440 MAMMOGRAPHY	0.224733	0	12,466	0	0 54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.078768	0	116,214	0	0 54.02
54.03 03630 ULTRA SOUND	0.077753	0	107,714	0	0 54.03
55.00 05500 RADIOLOGY-THERAPEUTIC	0.092930	0	330,219	0	0 55.00
57.00 05700 CT SCAN	0.074498	0	259,956	0	0 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.280845	0	20,562	0	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0.089447	0	157,209	0	0 59.00
60.00 06000 LABORATORY	0.108798	0	854,173	0	0 60.00
65.00 06500 RESPIRATORY THERAPY	0.138494	0	44,687	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0.469721	0	72,203	0	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0.460305	0	34,854	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	0.460289	0	11,873	0	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0.225433	0	460	0	0 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.237186	0	61,527	0	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.239697	0	43,808	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.317830	0	180,047	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.298204	0	633,138	0	0 73.00
76.00 03190 CHEMOTHERAPY	0.200027	0	78,148	0	0 76.00
76.01 03020 WOUND CARE	0.257346	0	93,418	0	0 76.01
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0.000000	0	0	0	0 90.00
90.01 09001 ANDERSON OUTPATIENT CENTER	0.480726	0	212,543	0	0 90.01
90.02 04950 DIABETIC EDUCATION	0.000000	0	0	0	0 90.02
90.03 09002 MS CLINIC	0.000000	0	0	0	0 90.03
91.00 09100 EMERGENCY	0.132085	0	2,045,224	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.684660	0	75,234	0	0 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0.000000	0	0	0	0 95.00
200.00 Subtotal (see instructions)		0	6,796,644	0	0 200.00
201.00 Less PBP Clinic Lab. Services-Program Only charges			0	0	0 201.00
202.00 Net Charges (line 200 - line 201)		0	6,796,644	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part V Date/Time Prepared: 11/22/2023 10:37 am
		Title XIX	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	140,909	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	12,499	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	69,925	0		54.00
54.01 03440 MAMMOGRAPHY	2,802	0		54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	9,154	0		54.02
54.03 03630 ULTRA SOUND	8,375	0		54.03
55.00 05500 RADIOLOGY-THERAPEUTIC	30,687	0		55.00
57.00 05700 CT SCAN	19,366	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	5,775	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	14,062	0		59.00
60.00 06000 LABORATORY	92,932	0		60.00
65.00 06500 RESPIRATORY THERAPY	6,189	0		65.00
66.00 06600 PHYSICAL THERAPY	33,915	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	16,043	0		67.00
68.00 06800 SPEECH PATHOLOGY	5,465	0		68.00
69.00 06900 ELECTROCARDIOLOGY	104	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	14,593	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10,501	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	57,224	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	188,804	0		73.00
76.00 03190 CHEMOTHERAPY	15,632	0		76.00
76.01 03020 WOUND CARE	24,041	0		76.01
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 ANDERSON OUTPATIENT CENTER	102,175	0		90.01
90.02 04950 DIABETIC EDUCATION	0	0		90.02
90.03 09002 MS CLINIC	0	0		90.03
91.00 09100 EMERGENCY	270,143	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	51,510	0		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
200.00 Subtotal (see instructions)	1,202,825	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)	1,202,825	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/22/2023 10:37 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		22,150	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		22,150	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)		20,074	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)		2,752	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		30,463,399	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)		30,463,399	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		30,463,399	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,375.32	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,784,881	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,784,881	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0088		Period: From 07/01/2022 To 06/30/2023		Worksheet D-1 Date/Time Prepared: 11/22/2023 10:37 am	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	8,924,344	4,041	2,208.45	2,482	5,481,373	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					7,406,404	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)					16,672,658	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)					426,163	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					288,483	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					714,646	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					15,958,012	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)					2,076	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,375.32	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,855,164	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0088		Period: From 07/01/2022 To 06/30/2023		Worksheet D-1 Date/Time Prepared: 11/22/2023 10:37 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,564,117	30,463,399	0.051344	2,855,164	146,596	90.00
91.00	Nursing Program cost	0	30,463,399	0.000000	2,855,164	0	91.00
92.00	Allied health cost	0	30,463,399	0.000000	2,855,164	0	92.00
93.00	All other Medical Education	0	30,463,399	0.000000	2,855,164	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0088 Component CCN: 15-T088	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/22/2023 10:37 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,677	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,677	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,677	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)		1,122	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,208,119	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)		3,208,119	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,208,119	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,198.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,344,605	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)		1,344,605	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1	
				Component CCN: 15-T088		Date/Time Prepared: 11/22/2023 10:37 am	
				Title XVIII	Subprovider - IRF	PPS	
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				719,778		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)				2,064,383		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)				83,914		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				30,651		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				114,565		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				1,949,818		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges				0		54.00
55.00	Target amount per discharge				0.00		55.00
55.01	Permanent adjustment amount per discharge				0.00		55.01
55.02	Adjustment amount per discharge (contractor use only)				0.00		55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)				0		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0		57.00
58.00	Bonus payment (see instructions)				0		58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)				0.00		59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)				0.00		60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)				0		61.00
62.00	Relief payment (see instructions)				0		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions				0		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)				0		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00		88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0088 Component CCN: 15-T088	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/22/2023 10:37 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	200,221	3,208,119	0.062411	0	0	90.00
91.00	Nursing Program cost	0	3,208,119	0.000000	0	0	91.00
92.00	Allied health cost	0	3,208,119	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,208,119	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/22/2023 10:37 am
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		22,150	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		22,150	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)		20,074	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)		889	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)		547	15.00
16.00	Nursery days (title V or XIX only)		452	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		30,463,399	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)		30,463,399	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		30,463,399	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,375.32	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,222,659	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)		1,222,659	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0088		Period: From 07/01/2022 To 06/30/2023		Worksheet D-1 Date/Time Prepared: 11/22/2023 10:37 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Hospital Cost	
Cost Center Description		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	647,261	547	1,183.29	452	534,847	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	8,924,344	4,041	2,208.45	219	483,651	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1,959,413	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)					4,200,570	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,076	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,375.32	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,855,164	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0088		Period: From 07/01/2022 To 06/30/2023		Worksheet D-1 Date/Time Prepared: 11/22/2023 10:37 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,564,117	30,463,399	0.051344	2,855,164	146,596	90.00
91.00	Nursing Program cost	0	30,463,399	0.000000	2,855,164	0	91.00
92.00	Allied health cost	0	30,463,399	0.000000	2,855,164	0	92.00
93.00	All other Medical Education	0	30,463,399	0.000000	2,855,164	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0088 Component CCN: 15-T088	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/22/2023 10:37 am
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,677 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,677 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			2,677 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)			37 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)			547 15.00
16.00	Nursery days (title V or XIX only)			452 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			3,208,119 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)			3,208,119 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			3,208,119 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,198.40 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			44,341 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)			44,341 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0088		Period: From 07/01/2022 To 06/30/2023		Worksheet D-1	
		Component CCN: 15-T088				Date/Time Prepared: 11/22/2023 10:37 am	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					28,409	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)					72,750	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0088 Component CCN: 15-T088	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/22/2023 10:37 am
	Title XIX	Subprovider - IRF	Cost

Cost Center Description						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	200,221	3,208,119	0.062411	0	0	90.00
91.00	Nursing Program cost	0	3,208,119	0.000000	0	0	91.00
92.00	Allied health cost	0	3,208,119	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,208,119	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet D-3 Date/Time Prepared: 11/22/2023 10:37 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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		9,782,435	30.00
31.00	03100	INTENSIVE CARE UNIT		4,713,625	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.126093	8,305,997	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.685441	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.324879	1,231,223	54.00
54.01	03440	MAMMOGRAPHY	0.224733	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.078768	326,566	54.02
54.03	03630	ULTRA SOUND	0.077753	0	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0.092930	130,356	55.00
57.00	05700	CT SCAN	0.074498	1,044,560	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.280845	133,000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.089447	1,561,918	59.00
60.00	06000	LABORATORY	0.108798	7,791,172	60.00
65.00	06500	RESPIRATORY THERAPY	0.138494	4,118,041	65.00
66.00	06600	PHYSICAL THERAPY	0.469721	554,542	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.460305	363,487	67.00
68.00	06800	SPEECH PATHOLOGY	0.460289	180,410	68.00
69.00	06900	ELECTROCARDIOLOGY	0.225433	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.237186	97,667	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.239697	2,029,327	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.317830	2,211,208	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.298204	5,227,531	73.00
76.00	03190	CHEMOTHERAPY	0.200027	0	76.00
76.01	03020	WOUND CARE	0.257346	0	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	0.480726	0	90.01
90.02	04950	DIABETIC EDUCATION	0.000000	0	90.02
90.03	09002	MS CLINIC	0.000000	0	90.03
91.00	09100	EMERGENCY	0.132085	4,136,834	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.684660	613,262	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		40,057,101	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)		40,057,101	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0088 Component CCN:15-T088	Period: From 07/01/2022 To 06/30/2023	Worksheet D-3 Date/Time Prepared: 11/22/2023 10:37 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
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF		2,110,831	41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.126093	23,962	3,021 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.685441	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.324879	37,912	12,317 54.00
54.01	03440 MAMMOGRAPHY	0.224733	0	0 54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.078768	3,887	306 54.02
54.03	03630 ULTRA SOUND	0.077753	0	0 54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0.092930	0	0 55.00
57.00	05700 CT SCAN	0.074498	18,140	1,351 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.280845	6,650	1,868 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.089447	13,290	1,189 59.00
60.00	06000 LABORATORY	0.108798	411,960	44,820 60.00
65.00	06500 RESPIRATORY THERAPY	0.138494	213,913	29,626 65.00
66.00	06600 PHYSICAL THERAPY	0.469721	486,738	228,631 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.460305	518,019	238,447 67.00
68.00	06800 SPEECH PATHOLOGY	0.460289	125,436	57,737 68.00
69.00	06900 ELECTROCARDIOLOGY	0.225433	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.237186	4,186	993 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.239697	111,289	26,676 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.317830	1,763	560 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.298204	228,085	68,016 73.00
76.00	03190 CHEMOTHERAPY	0.200027	0	0 76.00
76.01	03020 WOUND CARE	0.257346	0	0 76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000	0	0 90.00
90.01	09001 ANDERSON OUTPATIENT CENTER	0.480726	0	0 90.01
90.02	04950 DIABETIC EDUCATION	0.000000	0	0 90.02
90.03	09002 MS CLINIC	0.000000	0	0 90.03
91.00	09100 EMERGENCY	0.132085	31,946	4,220 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.684660	0	0 92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,237,176	719,778 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net charges (line 200 minus line 201)		2,237,176	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet D-3 Date/Time Prepared: 11/22/2023 10:37 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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		3,375,799	30.00
31.00	03100	INTENSIVE CARE UNIT		1,747,865	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		85,838	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.126093	1,354,352	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.685441	255,051	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.324879	438,887	54.00
54.01	03440	MAMMOGRAPHY	0.224733	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.078768	0	54.02
54.03	03630	ULTRA SOUND	0.077753	132,656	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0.092930	4,576	55.00
57.00	05700	CT SCAN	0.074498	317,665	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.280845	63,225	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.089447	409,338	59.00
60.00	06000	LABORATORY	0.108798	2,577,633	60.00
65.00	06500	RESPIRATORY THERAPY	0.138494	994,629	65.00
66.00	06600	PHYSICAL THERAPY	0.469721	135,021	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.460305	63,520	67.00
68.00	06800	SPEECH PATHOLOGY	0.460289	21,639	68.00
69.00	06900	ELECTROCARDIOLOGY	0.225433	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.237186	22,135	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.239697	389,651	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.317830	94,806	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.298204	1,684,043	73.00
76.00	03190	CHEMOTHERAPY	0.200027	1,356	76.00
76.01	03020	WOUND CARE	0.257346	1,086	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	0.480726	1,568	90.01
90.02	04950	DIABETIC EDUCATION	0.000000	0	90.02
90.03	09002	MS CLINIC	0.000000	0	90.03
91.00	09100	EMERGENCY	0.132085	1,736,561	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.684660	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		10,699,398	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)		10,699,398	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0088 Component CCN:15-T088	Period: From 07/01/2022 To 06/30/2023	Worksheet D-3 Date/Time Prepared: 11/22/2023 10:37 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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF		137,230	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.126093	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.685441	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.324879	1,220	54.00
54.01	03440	MAMMOGRAPHY	0.224733	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.078768	0	54.02
54.03	03630	ULTRA SOUND	0.077753	0	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0.092930	0	55.00
57.00	05700	CT SCAN	0.074498	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.280845	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.089447	0	59.00
60.00	06000	LABORATORY	0.108798	24,903	60.00
65.00	06500	RESPIRATORY THERAPY	0.138494	2,583	65.00
66.00	06600	PHYSICAL THERAPY	0.469721	19,552	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.460305	21,741	67.00
68.00	06800	SPEECH PATHOLOGY	0.460289	5,033	68.00
69.00	06900	ELECTROCARDIOLOGY	0.225433	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.237186	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.239697	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.317830	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.298204	11,528	73.00
76.00	03190	CHEMOTHERAPY	0.200027	0	76.00
76.01	03020	WOUND CARE	0.257346	0	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	ANDERSON OUTPATIENT CENTER	0.480726	0	90.01
90.02	04950	DIABETIC EDUCATION	0.000000	0	90.02
90.03	09002	MS CLINIC	0.000000	0	90.03
91.00	09100	EMERGENCY	0.132085	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.684660	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		86,560	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)		86,560	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part A Date/Time Prepared: 11/22/2023 10:37 am
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments			0 1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		2,379,703	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		7,505,313	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)		58,686	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		407,555	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)		137.93	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
5.01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)		0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)		0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)		0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		7.14	30.00
31.00	Percentage of Medicaid patient days (see instructions)		31.69	31.00
32.00	Sum of lines 30 and 31		38.83	32.00
33.00	Allowable disproportionate share percentage (see instructions)		21.25	33.00
34.00	Disproportionate share adjustment (see instructions)		525,142	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part A Date/Time Prepared: 11/22/2023 10:37 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Payment Adjustment				
35.00	Total uncompensated care amount (see instructions)	7,192,008,710	6,874,403,459	35.00
35.01	Factor 3 (see instructions)	0.000310627	0.000291857	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	2,234,032	2,006,341	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	563,099	1,500,633	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	2,063,732		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0	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	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)	12,940,131		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions))	0		48.00
		Amount		
		1.00		
49.00	Total payment for inpatient operating costs (see instructions)		12,940,131	49.00
50.00	Payment for inpatient program capital (from wkst. L, Pt. I and Pt. II, as applicable)		809,400	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		9,273	53.00
54.00	Special add-on payments for new technologies		175,522	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)		5,646	58.00
59.00	Total (sum of amounts on lines 49 through 58)		13,939,972	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		13,939,972	61.00
62.00	Deductibles billed to program beneficiaries		1,150,356	62.00
63.00	Coinsurance billed to program beneficiaries		28,547	63.00
64.00	Allowable bad debts (see instructions)		126,754	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		82,390	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		81,627	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		12,843,459	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)		0	70.75
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		0	70.93
70.94	HRR adjustment amount (see instructions)		-77,361	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part A Date/Time Prepared: 11/22/2023 10:37 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)	0		0 70.97
70.98	Low Volume Payment-3	0		0 70.98
70.99	HAC adjustment amount (see instructions)			0 70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		12,766,098	71.00
71.01	Sequestration adjustment (see instructions)		255,322	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		11,827,938	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		682,838	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		323,651	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0 90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0 91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0 92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0 93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0 95.00
96.00	Time value of money for capital related expenses (see instructions)			0 96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	0 100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000 101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0 102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000 103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0 104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,379,703	0	2,379,703		2,379,703	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,505,313	0		7,505,313	7,505,313	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	58,686	0	58,686		58,686	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	407,555	0		407,555	407,555	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2125	0.2125	0.2125	0.2125		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	525,142	0	126,422	398,720	525,142	11.00
11.01	Uncompensated care payments	36.00	2,063,732	0	321,525	870,488	1,192,013	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	12,940,131	0	2,886,336	10,053,795	12,940,131	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	12,940,131	0	2,886,336	10,053,795	12,940,131	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	809,400	0	195,836	613,564	809,400	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/22/2023 10:37 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	175,522	0	21,277	154,245	175,522	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	3,103,449	10,821,604	13,925,053	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	742,588	0	180,984	561,604	742,588	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	6,068	0	48	6,020	6,068	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0818	0.0818	0.0818	0.0818		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	60,744	0	14,804	45,940	60,744	25.00
26.00	Total prospective capital payments (see instructions)	12.00	809,400	0	195,836	613,564	809,400	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

		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	2,379,703	2,379,703			2,379,703	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,505,313		7,505,313		7,505,313	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	58,686	58,686			58,686	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	407,555		407,555		407,555	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
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000			5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0		0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0		0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000			7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0		0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0		0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0		0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0		0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2125	0.2125	0.2125			10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	525,142	126,422	398,720		525,142	11.00
11.01	Uncompensated care payments	36.00	2,063,732	466,425	1,821,010		2,287,435	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0		0	12.00
13.00	Subtotal (see instructions)	47.00	12,940,131	3,031,236	9,908,895		12,940,131	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0		0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	12,940,131	3,031,236	9,908,895		12,940,131	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	809,400	195,836	613,564		809,400	16.00
17.00	Special add-on payments for new technologies	54.00	175,522	21,277	154,245		175,522	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0		0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0		0	18.00
19.00	SUBTOTAL			3,248,349	10,676,704		13,925,053	19.00

		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	742,588	180,984	561,604	742,588	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	6,068	48	6,020	6,068	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	0.0818	0.0818	0.0818		24.00	
25.00	Disproportionate share adjustment (see instructions)	11.00	60,744	14,804	45,940	60,744	25.00	
26.00	Total prospective capital payments (see instructions)	12.00	809,400	195,836	613,564	809,400	26.00	
		Wkst. E, Pt. A, line	(Amt. from wkst. E, Pt. A)					
		0	1.00	2.00	3.00	4.00		
27.00							27.00	
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00	
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00	
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00	
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01	
31.00	HRR adjustment (see instructions)	70.94	-77,361	0	-77,361	-77,361	31.00	
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01	
						(Amt. to wkst. E, Pt. A)		
		0	1.00	2.00	3.00	4.00		
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00	
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/22/2023 10:37 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,348	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		16,907,122	2.00
3.00	OPPS or REH payments		14,272,483	3.00
4.00	Outlier payment (see instructions)		65,620	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		33,918	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		1,348	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		4,520	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)		4,520	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		4,520	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		3,172	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)		1,348	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)		14,372,021	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,611,997	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)		11,761,372	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
28.50	REH facility payment amount		0	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)		11,761,372	30.00
31.00	Primary payer payments		1,614	31.00
32.00	Subtotal (line 30 minus line 31)		11,759,758	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		330,409	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		214,766	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		229,031	36.00
37.00	Subtotal (see instructions)		11,974,524	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		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)		11,974,524	40.00
40.01	Sequestration adjustment (see instructions)		239,490	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		11,722,306	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		12,728	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		25,000	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/22/2023 10:37 am
Title XVIII		Hospital	PPS
			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: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet E-1
Part I
Date/Time Prepared:
11/22/2023 10:37 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		11,827,938		11,722,306	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)		11,827,938		11,722,306	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		682,838		12,728	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		12,510,776		11,735,034	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0088 Component CCN: 15-T088		Period: From 07/01/2022 To 06/30/2023		Worksheet E-1 Part I Date/Time Prepared: 11/22/2023 10:37 am	
		Title XVIII		Subprovider - IRF		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		2,108,731		0		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		2,108,731		0		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0		6.01
6.02	SETTLEMENT TO PROGRAM		42,142		0		6.02
7.00	Total Medicare program liability (see instructions)		2,066,589		0		7.00
		0		Contractor Number	NPR Date (Mo/Day/Yr)		
				1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet E-1 Part II Date/Time Prepared: 11/22/2023 10:37 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (see instructions)			2.00
3.00	Medicare HMO days from wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (see instructions)			4.00
5.00	Total hospital charges from wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0088 Component CCN: 15-T088	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part III Date/Time Prepared: 11/22/2023 10:37 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			2,005,926 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0234 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			102,904 3.00
4.00	Outlier Payments			13,966 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			7.334247 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			2,122,796 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			2,122,796 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			2,122,796 19.00
20.00	Deductibles			14,136 20.00
21.00	Subtotal (line 19 minus line 20)			2,108,660 21.00
22.00	Coinsurance			4,668 22.00
23.00	Subtotal (line 21 minus line 22)			2,103,992 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			7,138 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			4,640 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			4,640 26.00
27.00	Subtotal (sum of lines 23 and 25)			2,108,632 27.00
28.00	Direct graduate medical education payments (from wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			132 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.98	Recovery of accelerated depreciation.			0 31.98
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			2,108,764 32.00
32.01	Sequestration adjustment (see instructions)			42,175 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			2,108,731 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			-42,142 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			42,927 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from wkst. E-3, Pt. III, line 4			13,966 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.			0.000000 99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)			0.000000 99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 11/22/2023 10:37 am
		Title XIX	Hospital	Cost
		Inpatient	Outpatient	
		1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	4,200,570		1.00
2.00	Medical and other services		1,202,825	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	4,200,570	1,202,825	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	4,200,570	1,202,825	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	10,846,386		8.00
9.00	Ancillary service charges	10,699,398	6,796,644	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	21,545,784	6,796,644	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	21,545,784	6,796,644	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	17,345,214	5,593,819	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	4,200,570	1,202,825	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	4,200,570	1,202,825	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	4,200,570	1,202,825	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	4,200,570	1,202,825	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	4,200,570	1,202,825	38.00
39.00	Direct graduate medical education payments (from wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	4,200,570	1,202,825	40.00
41.00	Interim payments	4,200,570	1,202,825	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0088 Component CCN: 15-T088	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 11/22/2023 10:37 am
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	72,750		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	72,750	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	72,750	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	702,264		8.00
9.00	Ancillary service charges	86,560	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	788,824	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	788,824	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	716,074	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	72,750	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	72,750	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	72,750	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	72,750	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	72,750	0	38.00
39.00	Direct graduate medical education payments (from wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	72,750	0	40.00
41.00	Interim payments	72,750	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet E-4 Date/Time Prepared: 11/22/2023 10:37 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)			0.00	1.01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
2.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)			0.00	2.26
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)			0.00	3.02
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)			0.00	4.21
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or if worksheet S-2, Part I, line 68, is "Y", see instructions.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	0.00		17.00
18.00	Per resident amount	0.00	0.00		18.00
18.01	Per resident amount under §131 of the CAA 2021	0.00	0.00		18.01
19.00	Approved amount for resident costs	0	0	0	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			0	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet E-4 Date/Time Prepared: 11/22/2023 10:37 am
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		Title XVIII	Hospital	PPS	
		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	6,356	8,118		26.00
27.00	Total Inpatient Days (see instructions)	26,908	26,908		27.00
28.00	Ratio of inpatient days to total inpatient days	0.236212	0.301695		28.00
29.00	Program direct GME amount	0	0	0	29.00
29.01	Percent reduction for MA DGME				29.01
30.00	Reduction for direct GME payments for Medicare Advantage		0	0	30.00
31.00	Net Program direct GME amount			0	31.00
				1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)					
32.00	Renal dialysis direct medical education costs (from wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			18,737,041	37.00
38.00	Organ acquisition and HSCT acquisition costs (see instructions)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			18,737,041	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			16,942,388	42.00
43.00	Primary payer payments (see instructions)			1,614	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			16,940,774	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			35,677,815	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.525173	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.474827	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			0	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			0	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			0	50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet E-5 Date/Time Prepared: 11/22/2023 10:37 am
Title XVIII			PPS	
			1.00	
TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2		0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)		0	4.00
5.00	The rate used to calculate the time value of money (see instructions)		0.00	5.00
6.00	Time value of money for operating expenses (see instructions)		0	6.00
7.00	Time value of money for capital related expenses (see instructions)		0	7.00

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

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet G

Date/Time Prepared:
11/22/2023 10:37 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	25,892	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	62,244,755	0	0	0	4.00
5.00	Other receivable	4,745,754	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-43,306,767	0	0	0	6.00
7.00	Inventory	4,522,239	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,518,763	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	29,750,636	0	0	0	11.00
FIXED ASSETS						
12.00	Land	5,292,602	0	0	0	12.00
13.00	Land improvements	2,968,724	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	114,421,345	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	60,176,114	0	0	0	23.00
24.00	Accumulated depreciation	-124,567,181	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	58,291,604	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	636,034	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	636,034	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	88,678,274	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,637,806	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,815,517	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	221,694	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	24,169,410	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	31,844,427	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	13,236,189	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	601,993	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	13,838,182	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	45,682,609	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	42,995,665				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)	42,995,665	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	88,678,274	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet G-1

Date/Time Prepared:
11/22/2023 10:37 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		24,906,408			0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		11,969,091				2.00
3.00	Total (sum of line 1 and line 2)		36,875,499			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	TRANSFER RESTRICTED FUNDS	6,120,166		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)		6,120,166		0		10.00
11.00	Subtotal (line 3 plus line 10)		42,995,665		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	MISCELLANEOUS	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	0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		42,995,665		0	0	19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	TRANSFER RESTRICTED FUNDS		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	MISCELLANEOUS		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: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/22/2023 10:37 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	51,457,527		51,457,527	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	5,035,978		5,035,978	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	56,493,505		56,493,505	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	19,544,506		19,544,506	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	19,544,506		19,544,506	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	76,038,011		76,038,011	17.00
18.00	Ancillary services	162,707,268	408,465,406	571,172,674	18.00
19.00	Outpatient services	0	70,426,657	70,426,657	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
27.01	OTHER (SPECIFY)	0	0	0	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	238,745,279	478,892,063	717,637,342	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		184,922,644		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		184,922,644		43.00

STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet G-3 Date/Time Prepared: 11/22/2023 10:37 am
			1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)		717,637,342	1.00
2.00	Less contractual allowances and discounts on patients' accounts		523,166,673	2.00
3.00	Net patient revenues (line 1 minus line 2)		194,470,669	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)		184,922,644	4.00
5.00	Net income from service to patients (line 3 minus line 4)		9,548,025	5.00
OTHER INCOME				
6.00	Contributions, donations, bequests, etc		0	6.00
7.00	Income from investments		0	7.00
8.00	Revenues from telephone and other miscellaneous communication services		0	8.00
9.00	Revenue from television and radio service		0	9.00
10.00	Purchase discounts		0	10.00
11.00	Rebates and refunds of expenses		0	11.00
12.00	Parking lot receipts		0	12.00
13.00	Revenue from laundry and linen service		0	13.00
14.00	Revenue from meals sold to employees and guests		370,438	14.00
15.00	Revenue from rental of living quarters		0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients		28	17.00
18.00	Revenue from sale of medical records and abstracts		2,210	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		38,435	21.00
22.00	Rental of hospital space		469,623	22.00
23.00	Governmental appropriations		0	23.00
24.00	LAB SERVICE REVENUE		0	24.00
24.01	SHARED REVENUE		405,463	24.01
24.02	OTHER (SPECIFY)		0	24.02
24.03	GRANTS REVENUE		453,093	24.03
24.04	MISC REVENUE		391,195	24.04
24.05	SCHOOL OF RAD TECH		28,914	24.05
24.06	OTHER (SPECIFY)		0	24.06
24.07	CONTRACT SERVICE REVENUE		31,441	24.07
24.08	OTHER (SPECIFY)		0	24.08
24.09	RESEARCH REVENUE		28,357	24.09
24.10	ASSETS RELEASED FROM RESTRICTED FUND		204,411	24.10
24.11	GAIN ON DISPOSAL OF ASSET		225	24.11
24.50	COVID-19 PHE Funding		0	24.50
25.00	Total other income (sum of lines 6-24)		2,423,833	25.00
26.00	Total (line 5 plus line 25)		11,971,858	26.00
27.00	EHR		0	27.00
27.01	RESTRUCTURING EXPENSE		0	27.01
27.02	FUND RAISING ACTIVITIES		0	27.02
27.03	OTHER EXPENSES		2,767	27.03
28.00	Total other expenses (sum of line 27 and subscripts)		2,767	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)		11,969,091	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet L Parts I-III Date/Time Prepared: 11/22/2023 10:37 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		742,588	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		6,068	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)		66.74	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)		7.14	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		31.69	8.00
9.00	Sum of lines 7 and 8		38.83	9.00
10.00	Allowable disproportionate share percentage (see instructions)		8.18	10.00
11.00	Disproportionate share adjustment (see instructions)		60,744	11.00
12.00	Total prospective capital payments (see instructions)		809,400	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00