This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet S Parts I-III Date/Time Prepared: 11/21/2023 1:47 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/21/2023 Time: 1:47 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ASCENSION ST. VINCENT KOKOMO (15-0010) 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	Becky Jacobson		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	11/21/2023 01:47:52 PM			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	397,963	29,169	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	-24,575	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	373,388	29,169	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: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 11/21/2023 1:47 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1907 WEST SYCAMORE	PO Box:			1.00
2.00	City: KOKOMO	State: IN	Zip Code: 46901	County: HOWARD	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ASCENSION ST. VINCENT KOKOMO	150010	29020	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	ASCENSION ST. VINCENT KOKOMO REHAB	15T010	29020	5	07/01/2002	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)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	Y	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: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2023 1:47 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	484	14	0	0	4,008	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	53	0	0	0	230		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2023 1:47 pm

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

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	N		60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	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: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2023 1:47 pm

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/(col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/(col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/(col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/(col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 11/21/2023 1:47 pm

		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.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
		1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.		0	88.00

		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00		0	89.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00

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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					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: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2023 1:47 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	956,854	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H046	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ST VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 250 W 96TH STREET, SUITE 215	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46260	143.00

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y	N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/21/2023 1:47 pm

			Y/N	Date	
			1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE				
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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	09/18/2023	Y	09/18/2023	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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II Date/Time Prepared: 11/21/2023 1:47 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	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.	JILL	HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ASCENSION HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	NOT APPLICABLE	JILL.HILL1@ASCENSION.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part II Date/Time Prepared: 11/21/2023 1:47 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER NET REVENUE MANAGEMENT		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: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 11/21/2023 1:47 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	98	35,770	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)		98	35,770	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	13	4,745	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)		111	40,515	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	18	6,570		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)		129				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)		8	2,920			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: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2023 1:47 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,348	226	13,616			1.00
2.00	HMO and other (see instructions)	4,637	4,008				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	751	230				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,348	226	13,616			7.00
8.00	INTENSIVE CARE UNIT	572	210	2,145			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		62	1,192			13.00
14.00	Total (see instructions)	4,920	498	16,953	0.00	405.99	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	1,858	53	3,683	0.00	0.00	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)			76			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	405.99	27.00
28.00	Observation Bed Days		0	982			28.00
29.00	Ambulance Trips	2,639					29.00
30.00	Employee discount days (see instruction)			99			30.00
31.00	Employee discount days - IRF			15			31.00
32.00	Labor & delivery days (see instructions)	0	0	1,411			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: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2023 1:47 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,164	51	4,675	1.00
2.00	HMO and other (see instructions)			908	1,361		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				16		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	1,164	51	4,675	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	153	3	269	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: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part II Date/Time Prepared: 11/21/2023 1:47 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	34,547,074	170,595	34,717,669	846,935.00	40.99	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		55,616	0	55,616	278.00	200.06	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		4,394,845	297,838	4,692,683	150,233.00	31.24	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		899,804	0	899,804	5,257.90	171.13	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		271,623	0	271,623	2,258.82	120.25	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		9,248,470	0	9,248,470	175,285.00	52.76	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,417,121	0	8,417,121			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		1,308,730	0	1,308,730			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		15,829	0	15,829			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		90,533	0	90,533			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part II Date/Time Prepared: 11/21/2023 1:47 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	782,384	-527,783	254,601	6,544.00	38.91	26.00
27.00	Administrative & General	5.00	1,669,489	-279,468	1,390,021	14,163.00	98.14	27.00
28.00	Administrative & General under contract (see inst.)		847,154	0	847,154	5,030.00	168.42	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,422,992	0	1,422,992	49,329.00	28.85	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,742,607	90,445	1,833,052	47,385.00	38.68	38.00
39.00	Central Services and Supply	14.00	196,130	2,626	198,756	8,857.00	22.44	39.00
40.00	Pharmacy	15.00	1,723,775	22,831	1,746,606	33,113.00	52.75	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part III Date/Time Prepared: 11/21/2023 1:47 pm

		Worksheet A Line Number	Amount Reported	Reclassification 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)		36,817,220	170,595	36,987,815	901,294.00	41.04	1.00
2.00	Excluded area salaries (see instructions)		4,394,845	297,838	4,692,683	150,233.00	31.24	2.00
3.00	Subtotal salaries (line 1 minus line 2)		32,422,375	-127,243	32,295,132	751,061.00	43.00	3.00
4.00	Subtotal other wages & related costs (see inst.)		10,419,897	0	10,419,897	182,801.72	57.00	4.00
5.00	Subtotal wage-related costs (see inst.)		8,432,950	0	8,432,950	0.00	26.11	5.00
6.00	Total (sum of lines 3 thru 5)		51,275,222	-127,243	51,147,979	933,862.72	54.77	6.00
7.00	Total overhead cost (see instructions)		8,384,531	-691,349	7,693,182	164,421.00	46.79	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part IV | Date/Time Prepared: 11/21/2023 1:47 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,761,633	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	198,462	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,595,760	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,196,724	9.00
10.00	Dental, Hearing and Vision Plan	114,879	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	56,409	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	290,470	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	-2,025	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	2,602,202	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	2,536	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	15,161	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,832,211	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: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part V Date/Time Prepared: 11/21/2023 1:47 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	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	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-10 | Date/Time Prepared: 11/21/2023 1:47 pm

		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)	0.192142	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	14,096,910	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		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	125,001,931	6.00
7.00	Medicaid cost (line 1 times line 6)	24,018,121	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)	9,921,211	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)	9,921,211	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)	6,954,111	1,054,141	8,008,252	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,336,177	1,054,141	2,390,318	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)	1,336,177	1,054,141	2,390,318	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)	5,179,657	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	189,639	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	291,751	27.01
28.00	Non-Medicare bad debt expense (see instructions)	4,887,906	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,041,284	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,431,602	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	13,352,813	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/21/2023 1:47 pm

		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		4,008,741	4,008,741	-5,116	4,003,625	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,547,579	3,547,579	0	3,547,579	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	782,384	7,820,572	8,602,956	-698,378	7,904,578	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,669,489	46,742,970	48,412,459	-297,963	48,114,496	5.00
7.00	00700	OPERATION OF PLANT	0	4,846,980	4,846,980	0	4,846,980	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	387,727	387,727	462,705	850,432	8.00
9.00	00900	HOUSEKEEPING	0	1,647,623	1,647,623	-407,968	1,239,655	9.00
10.00	01000	DIETARY	0	2,613,865	2,613,865	-1,211,017	1,402,848	10.00
11.00	01100	CAFETERIA	0	0	0	1,211,017	1,211,017	11.00
13.00	01300	NURSING ADMINISTRATION	1,742,607	541,734	2,284,341	95,705	2,380,046	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	196,130	134,424	330,554	2,626	333,180	14.00
15.00	01500	PHARMACY	1,723,775	478,116	2,201,891	22,831	2,224,722	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	37	37	0	37	16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	96,166	36,358	132,524	189,052	321,576	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,663,955	1,433,654	8,097,609	735,521	8,833,130	30.00
31.00	03100	INTENSIVE CARE UNIT	1,678,981	449,023	2,128,004	70,112	2,198,116	31.00
41.00	04100	SUBPROVIDER - IRF	1,181,360	137,246	1,318,606	59,575	1,378,181	41.00
43.00	04300	NURSERY	0	0	0	558,397	558,397	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,014,800	3,155,273	6,170,073	43,372	6,213,445	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,997,695	546,033	2,543,728	-975,281	1,568,447	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,686,798	970,573	2,657,371	-177,964	2,479,407	54.00
54.01	03630	ULTRA SOUND	331,597	37,799	369,396	3,322	372,718	54.01
56.00	05600	RADIOISOTOPE	653,241	386,894	1,040,135	6,924	1,047,059	56.00
57.00	05700	CT SCAN	766,732	108,786	875,518	7,681	883,199	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	337,617	40,017	377,634	3,382	381,016	58.00
60.00	06000	LABORATORY	0	6,368,970	6,368,970	0	6,368,970	60.00
65.00	06500	RESPIRATORY THERAPY	1,473,115	252,030	1,725,145	16,146	1,741,291	65.00
66.00	06600	PHYSICAL THERAPY	605,283	4,595,994	5,201,277	-1,288,307	3,912,970	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,273,796	1,273,796	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	171,344	171,344	68.00
69.00	06900	ELECTROCARDIOLOGY	332,231	78,333	410,564	9,249	419,813	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	535,857	136,590	672,447	-3,037	669,410	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,413,615	1,413,615	0	1,413,615	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,757,136	3,757,136	0	3,757,136	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,200,372	16,200,372	0	16,200,372	73.00
74.00	07400	RENAL DIALYSIS	0	314,149	314,149	0	314,149	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	870,756	83,101	953,857	9,662	963,519	76.00
76.01	03190	CHEMOTHERAPY	634,740	95,320	730,060	12,574	742,634	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	273,756	494,456	768,212	3,966	772,178	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,180,690	2,291,741	4,472,431	43,887	4,516,318	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,583,573	773,467	3,357,040	46,837	3,403,877	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,013,328	116,927,298	150,940,626	-5,348	150,935,278	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	381,150	2,834,880	3,216,030	3,819	3,219,849	192.00
192.01	19201	ASC MOB	0	2,950	2,950	0	2,950	192.01
192.02	19202	EDUCATION CENTER	0	15,179	15,179	0	15,179	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	GIFT SHOP	0	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	152,596	36,145	188,741	1,529	190,270	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	34,547,074	119,816,452	154,363,526	0	154,363,526	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/21/2023 1:47 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-629,945	3,373,680		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-36,863	3,510,716		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-501,213	7,403,365		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-17,449,352	30,665,144		5.00
7.00	00700	OPERATION OF PLANT	-4,733	4,842,247		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	850,432		8.00
9.00	00900	HOUSEKEEPING	0	1,239,655		9.00
10.00	01000	DIETARY	-76,909	1,325,939		10.00
11.00	01100	CAFETERIA	-425,154	785,863		11.00
13.00	01300	NURSING ADMINISTRATION	-118,732	2,261,314		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	-541,806	-208,626		14.00
15.00	01500	PHARMACY	0	2,224,722		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	37		16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	-23,579	297,997		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-19,968	8,813,162		30.00
31.00	03100	INTENSIVE CARE UNIT	-678	2,197,438		31.00
41.00	04100	SUBPROVIDER - IRF	0	1,378,181		41.00
43.00	04300	NURSERY	0	558,397		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-297,554	5,915,891		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-48,414	1,520,033		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-272,698	2,206,709		54.00
54.01	03630	ULTRA SOUND	-2,140	370,578		54.01
56.00	05600	RADIOISOTOPE	18	1,047,077		56.00
57.00	05700	CT SCAN	-902	882,297		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	381,016		58.00
60.00	06000	LABORATORY	0	6,368,970		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,741,291		65.00
66.00	06600	PHYSICAL THERAPY	-3,845	3,909,125		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,273,796		67.00
68.00	06800	SPEECH PATHOLOGY	0	171,344		68.00
69.00	06900	ELECTROCARDIOLOGY	0	419,813		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	669,410		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,413,615		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,757,136		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,200,372		73.00
74.00	07400	RENAL DIALYSIS	0	314,149		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-9,500	954,019		76.00
76.01	03190	CHEMOTHERAPY	-11,030	731,604		76.01
76.02	03330	ENDOSCOPY	0	0		76.02
76.03	03950	WOUND CARE CENTER	0	772,178		76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-777,556	3,738,762		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	27,717	3,431,594		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-21,224,836	129,710,442		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,219,849		192.00
192.01	19201	ASC MOB	0	2,950		192.01
192.02	19202	EDUCATION CENTER	0	15,179		192.02
192.03	19203	MARKETING	0	0		192.03
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	FOUNDATION	0	0		194.00
194.01	07951	GIFT SHOP	0	0		194.01
194.02	07952	CLINIC OF HOPE	0	190,270		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-21,224,836	133,138,690		200.00

RECLASSIFICATIONS | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/21/2023 1:47 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LAUNDRY RECLASS				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	462,705	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		0	462,705	
	B - NURSERY RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	385,600	105,397	1.00
2.00	NURSERY	43.00	438,532	119,865	2.00
	0		824,132	225,262	
	C - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	0	1,211,017	1.00
	0		0	1,211,017	
	D - PT_OT_SPEECH RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	148,234	1,125,562	1.00
2.00	SPEECH PATHOLOGY	68.00	19,940	151,404	2.00
	0		168,174	1,276,966	
	E - RADIOLOGY TECHNICIAN RECLASS				
1.00	ALLIED HEALTH RAD TECH PROGRAM	23.00	188,089	0	1.00
	0		188,089	0	
	F - INTEREST EXPENSE A&G				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,116	1.00
	0		0	5,116	
	G - PTO SALARY ACCRUAL				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	170,595	0	1.00
	0		170,595	0	
	H - STARP SALARY RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2,526	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	16,726	0	2.00
3.00	NURSING ADMINISTRATION	13.00	17,458	0	3.00
4.00	CENTRAL SERVICE & SUPPLY	14.00	1,965	0	4.00
5.00	PHARMACY	15.00	17,270	0	5.00
6.00	ALLIED HEALTH RAD TECH PROGRAM	23.00	963	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	66,788	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	16,821	0	8.00
9.00	SUBPROVIDER - IRF	41.00	11,835	0	9.00
10.00	OPERATING ROOM	50.00	30,198	0	10.00
11.00	DELIVERY ROOM & LABOR ROOM	52.00	20,014	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	16,899	0	12.00
13.00	ULTRA SOUND	54.01	3,322	0	13.00
14.00	RADIOISOTOPE	56.00	6,544	0	14.00
15.00	CT SCAN	57.00	7,681	0	15.00
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	3,382	0	16.00
17.00	RESPIRATORY THERAPY	65.00	14,758	0	17.00
18.00	PHYSICAL THERAPY	66.00	6,064	0	18.00
19.00	ELECTROCARDIOLOGY	69.00	3,328	0	19.00
20.00	ELECTROENCEPHALOGRAPHY	70.00	5,368	0	20.00
21.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	8,724	0	21.00
22.00	CHEMOTHERAPY	76.01	6,359	0	22.00
23.00	WOUND CARE CENTER	76.03	2,743	0	23.00
24.00	EMERGENCY	91.00	21,847	0	24.00
25.00	AMBULANCE SERVICES	95.00	25,883	0	25.00
26.00	PHYSICIANS' PRIVATE OFFICES	192.00	3,819	0	26.00
27.00	CLINIC OF HOPE	194.02	1,529	0	27.00
	0		340,814	0	
	J - PTO PAYOUT RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	3,582	0	1.00
2.00	NURSING ADMINISTRATION	13.00	6,206	0	2.00
3.00	CENTRAL SERVICE & SUPPLY	14.00	661	0	3.00
4.00	PHARMACY	15.00	5,561	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	45,316	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	23,144	0	6.00
7.00	SUBPROVIDER - IRF	41.00	7,013	0	7.00
8.00	OPERATING ROOM	50.00	13,174	0	8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	7,409	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	3,863	0	10.00
11.00	RADIOISOTOPE	56.00	380	0	11.00
12.00	RESPIRATORY THERAPY	65.00	1,388	0	12.00
13.00	PHYSICAL THERAPY	66.00	184,615	0	13.00
14.00	ELECTROCARDIOLOGY	69.00	5,921	0	14.00

RECLASSIFICATIONS | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/21/2023 1:47 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
15.00	ELECTROENCEPHALOGRAPHY	70.00	1,624	0		15.00
16.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	938	0		16.00
17.00	CHEMOTHERAPY	76.01	6,215	0		17.00
18.00	WOUND CARE CENTER	76.03	1,223	0		18.00
19.00	EMERGENCY	91.00	20,903	0		19.00
20.00	AMBULANCE SERVICES	95.00	20,954	0		20.00
	0		360,090	0		
	K - SYSTEM PROJECTS					
1.00	NURSING ADMINISTRATION	13.00	66,781	5,260		1.00
2.00	ADULTS & PEDIATRICS	30.00	122,752	9,668		2.00
3.00	INTENSIVE CARE UNIT	31.00	27,946	2,201		3.00
4.00	SUBPROVIDER - IRF	41.00	37,753	2,974		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	43,281	3,409		5.00
6.00	PHYSICAL THERAPY	66.00	95	7		6.00
7.00	ELECTROENCEPHALOGRAPHY	70.00	114	9		7.00
8.00	EMERGENCY	91.00	1,054	83		8.00
	0		299,776	23,611		
500.00	Grand Total: Increases		2,351,670	3,204,677		500.00

RECLASSIFICATIONS | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/21/2023 1:47 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LAUNDRY RECLASS						
1.00	HOUSEKEEPING	9.00	0	407,968	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,637	0		2.00
3.00	PHYSICAL THERAPY	66.00	0	33,948	0		3.00
4.00	ELECTROENCEPHALOGRAPHY	70.00	0	10,152	0		4.00
	0		0	462,705			
	B - NURSERY RECLASS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	824,132	225,262	0		1.00
2.00		0.00	0	0	0		2.00
	0		824,132	225,262			
	C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	0	1,211,017	0		1.00
	0		0	1,211,017			
	D - PT_OT_SPEECH RECLASS						
1.00	PHYSICAL THERAPY	66.00	168,174	1,276,966	0		1.00
2.00		0.00	0	0	0		2.00
	0		168,174	1,276,966			
	E - RADIOLOGY TECHNICIAN RECLASS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	188,089	0	0		1.00
	0		188,089	0			
	F - INTEREST EXPENSE A&G						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,116	11		1.00
	0		0	5,116			
	G - PTO SALARY ACCRUAL						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	170,595	0		1.00
	0		0	170,595			
	H - STARP SALARY RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	340,814	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
	0		340,814	0			
	J - PTO PAYOUT RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	360,090	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

RECLASSIFICATIONS | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/21/2023 1:47 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
	0		360,090	0			
	K - SYSTEM PROJECTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	299,776	23,611	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
	0		299,776	23,611			
500.00	Grand Total: Decreases		2,181,075	3,375,272			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 11/21/2023 1:47 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	671,919	0	0	0	146,640	1.00
2.00	Land Improvements	2,316,541	0	0	0	0	2.00
3.00	Buildings and Fixtures	58,341,179	720,593	0	720,593	1,084,603	3.00
4.00	Building Improvements	25,171,802	6,510,992	0	6,510,992	0	4.00
5.00	Fixed Equipment	20,718,982	0	0	0	0	5.00
6.00	Movable Equipment	52,581,896	1,482,457	0	1,482,457	8,216,623	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	159,802,319	8,714,042	0	8,714,042	9,447,866	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	159,802,319	8,714,042	0	8,714,042	9,447,866	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	525,279	0	1.00
2.00	Land Improvements	2,316,541	0	2.00
3.00	Buildings and Fixtures	57,977,169	0	3.00
4.00	Building Improvements	31,682,794	0	4.00
5.00	Fixed Equipment	20,718,982	0	5.00
6.00	Movable Equipment	45,847,730	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	159,068,495	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	159,068,495	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 11/21/2023 1:47 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,995,119	417,951	564,128	0	31,543	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,510,560	37,019	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,505,679	454,970	564,128	0	31,543	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	4,008,741	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,547,579	2.00
3.00	Total (sum of lines 1-2)	0	7,556,320	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 11/21/2023 1:47 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	2,995,119	417,951	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,473,697	37,019	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,468,816	454,970	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	-70,933	0	31,543	0	3,373,680	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	3,510,716	2.00
3.00	Total (sum of lines 1-2)	-70,933	0	31,543	0	6,884,396	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/21/2023 1:47 pm

	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	-625,945	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	0	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-9,964	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,231,261			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	2,760,082			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-425,154	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-632	ADMINISTRATIVE & GENERAL	5.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,779	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	LOBBYING EXPENSE OFFSET	A	-28,120	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/21/2023 1:47 pm

	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	
33.01	BUILDING RENTAL INCOME PROPERTY MGMT	B	-24,598	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	BUILDING RENTAL INCOME PROPERTY MGMT	B	-16,298	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISC. INCOME SURGERY	B	-208	OPERATING ROOM	50.00	0	33.03
33.04	MISC. INCOME PATIENT INTEREST INCOME	B	-13,627	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MISC. INCOME RECYCLING	B	-428	OPERATION OF PLANT	7.00	0	33.05
33.06	MISC. INCOME SALE OF SCRAP	B	-86	OPERATION OF PLANT	7.00	0	33.06
33.07	MISC. INCOME MEDICAL AFFAIRS DUES	B	-9,420	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MISC. INCOME SOUTHWAY REHAB	B	-1,680	PHYSICAL THERAPY	66.00	0	33.08
33.09	MISC. INCOME MAMMMOGRAPHY	B	-812	RADIOLOGY-DIAGNOSTIC	54.00	0	33.09
33.10	MISC. INCOME FOREST PARK REHAB	B	-2,025	PHYSICAL THERAPY	66.00	0	33.10
33.11	MISC. INCOME RAD TECH TUITION	B	-23,138	ALLIED HEALTH RAD TECH PROGRAM	23.00	0	33.11
33.12	MISC. INCOME ULTRASOUND	B	-2,140	ULTRA SOUND	54.01	0	33.12
33.13	MISC. INCOME MEALS ON WHEELS	B	-75,130	DIETARY	10.00	0	33.13
33.14	MISC. INCOME GAIN ON SALE OF ASSETS	B	-36,863	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.14
33.15	MISC INCOME PERU REHAB	B	-140	PHYSICAL THERAPY	66.00	0	33.15
34.00	PROVIDER TAX EXPENSE	A	-12,884,388	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	PHYSICIAN FUND EXPENSE	A	-6,286,376	ADMINISTRATIVE & GENERAL	5.00	0	34.01
34.02	PHYSICIAN FUND EXPENSE	A	-1,243,986	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.02
34.03	MID LEVEL PROVIDER OFFSET	A	-19,668	ADULTS & PEDIATRICS	30.00	0	34.03
34.04	MID LEVEL PROVIDER OFFSET	A	-678	INTENSIVE CARE UNIT	31.00	0	34.04
34.05	MID LEVEL PROVIDER OFFSET	A	-9,500	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	34.05
34.06	ANDERSON AMBULANCE EXPENSES	A	27,717	AMBULANCE SERVICES	95.00	0	34.06
35.00	TELEVISION EXPENSE UTILITIES	A	-4,219	OPERATION OF PLANT	7.00	0	35.00
35.01	INTEREST INCOME	B	-5,116	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.02	BAD DEBT NON-PATIENT CHEMOTHERAPY	A	-8,630	CHEMOTHERAPY	76.01	0	35.02
35.03	ENTERTAINMENT ADMINISTRATION	A	-2,163	ADMINISTRATIVE & GENERAL	5.00	0	35.03
35.04	ENTERTAINMENT LABOR AND DELIVERY	A	-7,463	NURSING ADMINISTRATION	13.00	0	35.04
35.05	DONATIONS	A	-6,000	ADMINISTRATIVE & GENERAL	5.00	0	35.05
35.06	DONATIONS	A	-5,000	NURSING ADMINISTRATION	13.00	0	35.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-21,224,836				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: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 11/21/2023 1:47 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	5,879,356	5,136,583	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE CAPITAL	1,772,411	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE INTEREST EXPENSE	65,817	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE INTEREST EXPENSE	544	0	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE OTHER	20,361,437	19,395,429	3.02
3.04	15.00	PHARMACY	SVH CHARGEBACK	-16,639	-16,639	3.04
3.05	23.00	ALLIED HEALTH RAD TECH PROGR	SVH CHARGEBACK	28,370	28,370	3.05
3.06	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACK	45,675	45,675	3.06
3.07	56.00	RADIOISOTOPE	SVH CHARGEBACK	10,437	10,437	3.07
3.08	69.00	ELECTROCARDIOLOGY	SVH CHARGEBACK	5,000	5,000	3.08
3.09	69.00	ELECTROCARDIOLOGY	SVH CHARGEBACK	5,000	5,000	3.09
3.10	194.02	CLINIC OF HOPE	SVH CHARGEBACK	1,307,129	1,307,129	3.10
3.12	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE A&G	4,572	0	3.12
3.13	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	560,128	564,128	3.13
4.00	5.00	ADMINISTRATIVE & GENERAL	TRG ADMINISTRATIVE FEES	-139,968	0	4.00
4.01	13.00	NURSING ADMINISTRATION	TRG ADMINISTRATIVE FEES	-106,269	0	4.01
4.02	14.00	CENTRAL SERVICE & SUPPLY	TRG ADMINISTRATIVE FEES	-541,806	0	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			29,241,194	26,481,112	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		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B		0.00	SVH HOME OFFICE	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-1 Date/Time Prepared: 11/21/2023 1:47 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	742,773	0		1.00
2.00	1,772,411	0		2.00
3.00	65,817	11		3.00
3.01	544	0		3.01
3.02	966,008	0		3.02
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
3.12	4,572	0		3.12
3.13	-4,000	11		3.13
4.00	-139,968	0		4.00
4.01	-106,269	0		4.01
4.02	-541,806	0		4.02
5.00	2,760,082			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			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 11/21/2023 1:47 pm

	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	5.00	DR. A	294,847	250,034	44,813	211,500	747	1.00
2.00	23.00	DR. B	441	441	0	0	0	2.00
3.00	50.00	DR. C	166,114	110,498	55,616	211,500	278	3.00
4.00	54.00	DR. D	34	34	0	0	0	4.00
5.00	56.00	DR. E	-18	-18	0	0	0	5.00
6.00	57.00	DR. F	902	902	0	0	0	6.00
7.00	76.01	DR. G	2,400	2,400	0	0	0	7.00
8.00	30.00	DR. H	300	300	0	0	0	8.00
9.00	52.00	DR. I	19,950	19,950	0	0	0	9.00
10.00	54.00	DR. J	229,032	229,032	0	0	0	10.00
11.00	91.00	DR. K	288,258	288,258	0	0	0	11.00
12.00	54.00	DR. L	36,128	36,128	0	0	0	12.00
13.00	91.00	DR. M	489,298	489,298	0	0	0	13.00
14.00	5.00	DR. N	582,000	582,000	0	0	0	14.00
15.00	50.00	DR. O	159,500	159,500	0	0	0	15.00
16.00	52.00	DR. P	28,464	28,464	0	0	0	16.00
17.00	54.00	DR. Q	6,692	6,692	0	0	0	17.00
200.00			2,304,342	2,203,913	100,429		1,025	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	5.00	DR. A	75,957	3,798	0	0	0	1.00
2.00	23.00	DR. B	0	0	0	0	0	2.00
3.00	50.00	DR. C	28,268	1,413	0	0	0	3.00
4.00	54.00	DR. D	0	0	0	0	0	4.00
5.00	56.00	DR. E	0	0	0	0	0	5.00
6.00	57.00	DR. F	0	0	0	0	0	6.00
7.00	76.01	DR. G	0	0	0	0	0	7.00
8.00	30.00	DR. H	0	0	0	0	0	8.00
9.00	52.00	DR. I	0	0	0	0	0	9.00
10.00	54.00	DR. J	0	0	0	0	0	10.00
11.00	91.00	DR. K	0	0	0	0	0	11.00
12.00	54.00	DR. L	0	0	0	0	0	12.00
13.00	91.00	DR. M	0	0	0	0	0	13.00
14.00	5.00	DR. N	0	0	0	0	0	14.00
15.00	50.00	DR. O	0	0	0	0	0	15.00
16.00	52.00	DR. P	0	0	0	0	0	16.00
17.00	54.00	DR. Q	0	0	0	0	0	17.00
200.00			104,225	5,211	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	5.00	DR. A	0	75,957	0	250,034		1.00
2.00	23.00	DR. B	0	0	0	441		2.00
3.00	50.00	DR. C	0	28,268	27,348	137,846		3.00
4.00	54.00	DR. D	0	0	0	34		4.00
5.00	56.00	DR. E	0	0	0	-18		5.00
6.00	57.00	DR. F	0	0	0	902		6.00
7.00	76.01	DR. G	0	0	0	2,400		7.00
8.00	30.00	DR. H	0	0	0	300		8.00
9.00	52.00	DR. I	0	0	0	19,950		9.00
10.00	54.00	DR. J	0	0	0	229,032		10.00
11.00	91.00	DR. K	0	0	0	288,258		11.00
12.00	54.00	DR. L	0	0	0	36,128		12.00
13.00	91.00	DR. M	0	0	0	489,298		13.00
14.00	5.00	DR. N	0	0	0	582,000		14.00
15.00	50.00	DR. O	0	0	0	159,500		15.00
16.00	52.00	DR. P	0	0	0	28,464		16.00
17.00	54.00	DR. Q	0	0	0	6,692		17.00
200.00			0	104,225	27,348	2,231,261		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/21/2023 1:47 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,373,680	3,373,680				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,510,716		3,510,716			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,403,365	130,496	0	7,533,861		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,665,144	510,108	34,283	303,868	31,513,403	5.00
7.00	00700	OPERATION OF PLANT	4,842,247	468,137	53,101	0	5,363,485	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	850,432	5,273	0	0	855,705	8.00
9.00	00900	HOUSEKEEPING	1,239,655	20,511	0	0	1,260,166	9.00
10.00	01000	DIETARY	1,325,939	52,982	11,208	0	1,390,129	10.00
11.00	01100	CAFETERIA	785,863	64,230	10,869	0	860,962	11.00
13.00	01300	NURSING ADMINISTRATION	2,261,314	55,588	131,207	400,718	2,848,827	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	-208,626	0	77,432	43,449	-87,745	14.00
15.00	01500	PHARMACY	2,224,722	32,563	6,972	381,820	2,646,077	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	37	24,908	2,276	0	27,221	16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	297,997	9,120	0	62,351	369,468	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,813,162	299,713	128,327	1,592,415	10,833,617	30.00
31.00	03100	INTENSIVE CARE UNIT	2,197,438	57,369	79,530	381,883	2,716,220	31.00
41.00	04100	SUBPROVIDER - IRF	1,378,181	138,110	490	270,627	1,787,408	41.00
43.00	04300	NURSERY	558,397	16,378	22,150	95,866	692,791	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,915,891	336,409	532,502	668,538	7,453,340	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,520,033	33,225	59,276	272,005	1,884,539	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,206,709	242,476	648,922	332,167	3,430,274	54.00
54.01	03630	ULTRA SOUND	370,578	0	103,401	73,216	547,195	54.01
56.00	05600	RADIOISOTOPE	1,047,077	20,358	483,125	144,317	1,694,877	56.00
57.00	05700	CT SCAN	882,297	0	0	169,292	1,051,589	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	381,016	0	235,756	74,545	691,317	58.00
60.00	06000	LABORATORY	6,368,970	80,415	2,978	0	6,452,363	60.00
65.00	06500	RESPIRATORY THERAPY	1,741,291	12,592	34,633	325,563	2,114,079	65.00
66.00	06600	PHYSICAL THERAPY	3,909,125	73,442	19,762	137,260	4,139,589	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,273,796	31,514	6,702	32,405	1,344,417	67.00
68.00	06800	SPEECH PATHOLOGY	171,344	10,586	901	4,359	187,190	68.00
69.00	06900	ELECTROCARDIOLOGY	419,813	40,747	126,775	74,650	661,985	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	669,410	27,769	17,263	118,696	833,138	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,413,615	43,862	1,821	0	1,459,298	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,757,136	0	0	0	3,757,136	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,200,372	0	0	0	16,200,372	73.00
74.00	07400	RENAL DIALYSIS	314,149	0	0	0	314,149	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	954,019	46,732	12,272	192,466	1,205,489	76.00
76.01	03190	CHEMOTHERAPY	731,604	0	476,217	141,507	1,349,328	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	772,178	30,537	8,083	60,712	871,510	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,738,762	196,864	102,706	486,290	4,524,622	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,431,594	40,391	68,614	575,026	4,115,625	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	129,710,442	3,153,405	3,499,554	7,416,011	129,361,155	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,219,849	207,969	2,108	84,157	3,514,083	192.00
192.01	19201	ASC MOB	2,950	0	8,148	0	11,098	192.01
192.02	19202	EDUCATION CENTER	15,179	0	0	0	15,179	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	0	1,832	0	0	1,832	194.00
194.01	07951	GIFT SHOP	0	10,474	0	0	10,474	194.01
194.02	07952	CLINIC OF HOPE	190,270	0	906	33,693	224,869	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	133,138,690	3,373,680	3,510,716	7,533,861	133,138,690	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/21/2023 1:47 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	31,513,403					5.00
7.00	00700	OPERATION OF PLANT	1,661,752	7,025,237				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	265,121	16,355	1,137,181			8.00
9.00	00900	HOUSEKEEPING	390,433	63,619	0	1,714,218		9.00
10.00	01000	DIETARY	430,699	164,337	0	40,561	2,025,726	10.00
11.00	01100	CAFETERIA	266,749	199,225	0	49,172	0	11.00
13.00	01300	NURSING ADMINISTRATION	882,644	172,419	0	42,556	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	819,826	101,001	0	24,929	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,434	77,259	0	19,069	0	16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	114,471	28,289	0	6,982	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,356,547	929,630	750,332	229,450	1,336,611	30.00
31.00	03100	INTENSIVE CARE UNIT	841,558	177,944	118,204	43,920	210,563	31.00
41.00	04100	SUBPROVIDER - IRF	553,787	428,380	202,958	105,732	361,540	41.00
43.00	04300	NURSERY	214,645	50,801	65,687	12,539	117,012	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,309,246	1,043,451	0	257,540	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	583,881	103,054	0	25,436	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,062,792	752,096	0	185,631	0	54.00
54.01	03630	ULTRA SOUND	169,536	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	525,119	63,146	0	15,586	0	56.00
57.00	05700	CT SCAN	325,811	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	214,189	0	0	0	0	58.00
60.00	06000	LABORATORY	1,999,116	249,425	0	61,563	0	60.00
65.00	06500	RESPIRATORY THERAPY	654,999	39,056	0	9,640	0	65.00
66.00	06600	PHYSICAL THERAPY	1,282,556	227,798	0	56,225	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	416,537	97,749	0	24,126	0	67.00
68.00	06800	SPEECH PATHOLOGY	57,997	32,836	0	8,104	0	68.00
69.00	06900	ELECTROCARDIOLOGY	205,101	126,386	0	31,194	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	258,129	86,131	0	21,259	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	452,130	136,047	0	33,579	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,164,062	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,019,272	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	97,332	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	373,493	144,951	0	35,777	0	76.00
76.01	03190	CHEMOTHERAPY	418,058	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	270,017	94,718	0	23,378	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,401,850	610,618	0	150,712	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,275,132	125,281	0	30,922	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,343,021	6,342,002	1,137,181	1,545,582	2,025,726	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,088,758	645,064	0	159,214	0	192.00
192.01	19201	ASC MOB	3,438	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	4,703	0	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	568	5,683	0	1,403	0	194.00
194.01	07951	GIFT SHOP	3,245	32,488	0	8,019	0	194.01
194.02	07952	CLINIC OF HOPE	69,670	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	31,513,403	7,025,237	1,137,181	1,714,218	2,025,726	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/21/2023 1:47 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	1,376,108					11.00
13.00	01300	NURSING ADMINISTRATION	92,399	4,038,845				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	17,271	0	-70,474			14.00
15.00	01500	PHARMACY	64,569	23,092	0	3,679,494		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	131,983	16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	12,848	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	361,937	1,482,697	0	0	6,448	30.00
31.00	03100	INTENSIVE CARE UNIT	81,939	441,358	0	0	2,106	31.00
41.00	04100	SUBPROVIDER - IRF	67,703	335,933	0	0	1,657	41.00
43.00	04300	NURSERY	18,618	135,726	0	0	525	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	122,703	568,486	0	0	20,630	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	55,549	363,223	0	0	3,832	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	76,095	14,573	0	0	5,419	54.00
54.01	03630	ULTRA SOUND	9,997	0	0	0	1,418	54.01
56.00	05600	RADIOISOTOPE	33,132	21,895	0	0	5,312	56.00
57.00	05700	CT SCAN	27,726	0	0	0	3,207	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	14,090	0	0	0	666	58.00
60.00	06000	LABORATORY	0	680	0	0	18,417	60.00
65.00	06500	RESPIRATORY THERAPY	69,317	25,514	0	0	3,178	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	2,714	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,038	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	169	68.00
69.00	06900	ELECTROCARDIOLOGY	14,978	30,824	0	0	3,189	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	28,604	0	0	0	1,475	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,882	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,359	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,679,494	16,471	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	346	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	51,941	14,701	0	0	462	76.00
76.01	03190	CHEMOTHERAPY	33,227	93,507	0	0	1,791	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	15,397	32,673	0	0	2,681	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	98,479	439,177	0	0	17,083	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	4,508	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,368,519	4,024,059	0	3,679,494	131,983	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	ASC MOB	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	GIFT SHOP	0	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	7,589	14,786	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	-70,474	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,376,108	4,038,845	-70,474	3,679,494	131,983	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/21/2023 1:47 pm

		Cost Center Description	ALLIED HEALTH RAD TECH PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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 SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	532,058					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	19,287,269	0	19,287,269		30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,633,812	0	4,633,812		31.00
41.00	04100	SUBPROVIDER - IRF	0	3,845,098	0	3,845,098		41.00
43.00	04300	NURSERY	0	1,308,344	0	1,308,344		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	11,775,396	0	11,775,396		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,019,514	0	3,019,514		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	179,934	5,706,814	0	5,706,814		54.00
54.01	03630	ULTRA SOUND	47,082	775,228	0	775,228		54.01
56.00	05600	RADIOISOTOPE	176,404	2,535,471	0	2,535,471		56.00
57.00	05700	CT SCAN	106,514	1,514,847	0	1,514,847		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	22,124	942,386	0	942,386		58.00
60.00	06000	LABORATORY	0	8,781,564	0	8,781,564		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,915,783	0	2,915,783		65.00
66.00	06600	PHYSICAL THERAPY	0	5,708,882	0	5,708,882		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,883,867	0	1,883,867		67.00
68.00	06800	SPEECH PATHOLOGY	0	286,296	0	286,296		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,073,657	0	1,073,657		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,228,736	0	1,228,736		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,084,936	0	2,084,936		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,924,557	0	4,924,557		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,915,609	0	24,915,609		73.00
74.00	07400	RENAL DIALYSIS	0	411,827	0	411,827		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,826,814	0	1,826,814		76.00
76.01	03190	CHEMOTHERAPY	0	1,895,911	0	1,895,911		76.01
76.02	03330	ENDOSCOPY	0	0	0	0		76.02
76.03	03950	WOUND CARE CENTER	0	1,310,374	0	1,310,374		76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	7,242,541	0	7,242,541		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,551,468	0	5,551,468		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	532,058	127,387,001	0	127,387,001		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,407,119	0	5,407,119		192.00
192.01	19201	ASC MOB	0	14,536	0	14,536		192.01
192.02	19202	EDUCATION CENTER	0	19,882	0	19,882		192.02
192.03	19203	MARKETING	0	0	0	0		192.03
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	FOUNDATION	0	9,486	0	9,486		194.00
194.01	07951	GIFT SHOP	0	54,226	0	54,226		194.01
194.02	07952	CLINIC OF HOPE	0	316,914	0	316,914		194.02
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	-70,474	0	-70,474		201.00
202.00		TOTAL (sum lines 118 through 201)	532,058	133,138,690	0	133,138,690		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/21/2023 1:47 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	130,496	0	130,496	130,496	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,772,411	510,108	34,283	2,316,802	5,264	5.00
7.00	00700	OPERATION OF PLANT	0	468,137	53,101	521,238	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,273	0	5,273	0	8.00
9.00	00900	HOUSEKEEPING	0	20,511	0	20,511	0	9.00
10.00	01000	DIETARY	0	52,982	11,208	64,190	0	10.00
11.00	01100	CAFETERIA	0	64,230	10,869	75,099	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	55,588	131,207	186,795	6,942	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	77,432	77,432	753	14.00
15.00	01500	PHARMACY	0	32,563	6,972	39,535	6,614	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	24,908	2,276	27,184	0	16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	0	9,120	0	9,120	1,080	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	299,713	128,327	428,040	27,572	30.00
31.00	03100	INTENSIVE CARE UNIT	0	57,369	79,530	136,899	6,615	31.00
41.00	04100	SUBPROVIDER - IRF	0	138,110	490	138,600	4,688	41.00
43.00	04300	NURSERY	0	16,378	22,150	38,528	1,661	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	336,409	532,502	868,911	11,581	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	33,225	59,276	92,501	4,712	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	242,476	648,922	891,398	5,754	54.00
54.01	03630	ULTRA SOUND	0	0	103,401	103,401	1,268	54.01
56.00	05600	RADIOISOTOPE	0	20,358	483,125	503,483	2,500	56.00
57.00	05700	CT SCAN	0	0	0	0	2,933	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	235,756	235,756	1,291	58.00
60.00	06000	LABORATORY	0	80,415	2,978	83,393	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	12,592	34,633	47,225	5,640	65.00
66.00	06600	PHYSICAL THERAPY	0	73,442	19,762	93,204	2,378	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	31,514	6,702	38,216	561	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,586	901	11,487	76	68.00
69.00	06900	ELECTROCARDIOLOGY	0	40,747	126,775	167,522	1,293	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	27,769	17,263	45,032	2,056	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	43,862	1,821	45,683	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	46,732	12,272	59,004	3,334	76.00
76.01	03190	CHEMOTHERAPY	0	0	476,217	476,217	2,451	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0	30,537	8,083	38,620	1,052	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	196,864	102,706	299,570	8,424	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	40,391	68,614	109,005	9,961	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,772,411	3,153,405	3,499,554	8,425,370	128,454	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	207,969	2,108	210,077	1,458	192.00
192.01	19201	ASC MOB	0	0	8,148	8,148	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	0	1,832	0	1,832	0	194.00
194.01	07951	GIFT SHOP	0	10,474	0	10,474	0	194.01
194.02	07952	CLINIC OF HOPE	0	0	906	906	584	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,772,411	3,373,680	3,510,716	8,656,807	130,496	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/21/2023 1:47 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,322,066					5.00
7.00	00700	OPERATION OF PLANT	122,448	643,686				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	19,536	1,498	26,307			8.00
9.00	00900	HOUSEKEEPING	28,770	5,829	0	55,110		9.00
10.00	01000	DIETARY	31,737	15,057	0	1,304	112,288	10.00
11.00	01100	CAFETERIA	19,656	18,254	0	1,581	0	11.00
13.00	01300	NURSING ADMINISTRATION	65,039	15,798	0	1,368	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	60,410	9,254	0	801	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	621	7,079	0	613	0	16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	8,435	2,592	0	224	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	247,331	85,177	17,358	7,377	74,089	30.00
31.00	03100	INTENSIVE CARE UNIT	62,011	16,304	2,734	1,412	11,672	31.00
41.00	04100	SUBPROVIDER - IRF	40,807	39,250	4,695	3,399	20,041	41.00
43.00	04300	NURSERY	15,816	4,655	1,520	403	6,486	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	170,160	95,605	0	8,278	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	43,024	9,442	0	818	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	78,313	68,911	0	5,968	0	54.00
54.01	03630	ULTRA SOUND	12,492	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	38,694	5,786	0	501	0	56.00
57.00	05700	CT SCAN	24,008	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15,783	0	0	0	0	58.00
60.00	06000	LABORATORY	147,307	22,854	0	1,979	0	60.00
65.00	06500	RESPIRATORY THERAPY	48,264	3,578	0	310	0	65.00
66.00	06600	PHYSICAL THERAPY	94,507	20,872	0	1,808	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,693	8,956	0	776	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,274	3,009	0	261	0	68.00
69.00	06900	ELECTROCARDIOLOGY	15,113	11,580	0	1,003	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	19,021	7,892	0	683	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,316	12,465	0	1,080	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	85,775	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	369,811	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	7,172	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	27,521	13,281	0	1,150	0	76.00
76.01	03190	CHEMOTHERAPY	30,805	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	19,897	8,679	0	752	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	103,297	55,948	0	4,845	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	93,960	11,479	0	994	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,235,824	581,084	26,307	49,688	112,288	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	80,227	59,104	0	5,119	0	192.00
192.01	19201	ASC MOB	253	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	347	0	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	42	521	0	45	0	194.00
194.01	07951	GIFT SHOP	239	2,977	0	258	0	194.01
194.02	07952	CLINIC OF HOPE	5,134	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,322,066	643,686	26,307	55,110	112,288	202.00

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		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	114,590					11.00
13.00	01300	NURSING ADMINISTRATION	7,694	283,636				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	1,438	0	79,623			14.00
15.00	01500	PHARMACY	5,377	1,622	0	123,613		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	35,497	16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	1,070	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,139	104,124	0	0	1,750	30.00
31.00	03100	INTENSIVE CARE UNIT	6,823	30,995	0	0	571	31.00
41.00	04100	SUBPROVIDER - IRF	5,638	23,592	0	0	450	41.00
43.00	04300	NURSERY	1,550	9,532	0	0	142	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,218	39,923	0	0	5,282	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,626	25,508	0	0	1,040	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,337	1,023	0	0	1,470	54.00
54.01	03630	ULTRA SOUND	832	0	0	0	385	54.01
56.00	05600	RADIOISOTOPE	2,759	1,538	0	0	1,441	56.00
57.00	05700	CT SCAN	2,309	0	0	0	870	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,173	0	0	0	181	58.00
60.00	06000	LABORATORY	0	48	0	0	4,997	60.00
65.00	06500	RESPIRATORY THERAPY	5,772	1,792	0	0	862	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	736	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	282	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	46	68.00
69.00	06900	ELECTROCARDIOLOGY	1,247	2,165	0	0	865	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,382	0	0	0	400	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,053	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	912	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	123,613	4,470	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	94	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,325	1,032	0	0	125	76.00
76.01	03190	CHEMOTHERAPY	2,767	6,567	0	0	486	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	1,282	2,295	0	0	728	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,200	30,842	0	0	4,636	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	1,223	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	113,958	282,598	0	123,613	35,497	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	ASC MOB	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	GIFT SHOP	0	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	632	1,038	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	79,623	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	114,590	283,636	79,623	123,613	35,497	202.00

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		Cost Center Description	ALLIED HEALTH RAD TECH PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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 SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	22,521					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		1,022,957	0	1,022,957		30.00
31.00	03100	INTENSIVE CARE UNIT		276,036	0	276,036		31.00
41.00	04100	SUBPROVIDER - IRF		281,160	0	281,160		41.00
43.00	04300	NURSERY		80,293	0	80,293		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		1,209,958	0	1,209,958		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		181,671	0	181,671		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		1,059,174	0	1,059,174		54.00
54.01	03630	ULTRA SOUND		118,378	0	118,378		54.01
56.00	05600	RADIOISOTOPE		556,702	0	556,702		56.00
57.00	05700	CT SCAN		30,120	0	30,120		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		254,184	0	254,184		58.00
60.00	06000	LABORATORY		260,578	0	260,578		60.00
65.00	06500	RESPIRATORY THERAPY		113,443	0	113,443		65.00
66.00	06600	PHYSICAL THERAPY		213,505	0	213,505		66.00
67.00	06700	OCCUPATIONAL THERAPY		79,484	0	79,484		67.00
68.00	06800	SPEECH PATHOLOGY		19,153	0	19,153		68.00
69.00	06900	ELECTROCARDIOLOGY		200,788	0	200,788		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		77,466	0	77,466		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		93,597	0	93,597		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		86,687	0	86,687		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		497,894	0	497,894		73.00
74.00	07400	RENAL DIALYSIS		7,266	0	7,266		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		109,772	0	109,772		76.00
76.01	03190	CHEMOTHERAPY		519,293	0	519,293		76.01
76.02	03330	ENDOSCOPY		0	0	0		76.02
76.03	03950	WOUND CARE CENTER		73,305	0	73,305		76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY		515,762	0	515,762		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		226,622	0	226,622		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	8,165,248	0	8,165,248		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES		355,985	0	355,985		192.00
192.01	19201	ASC MOB		8,401	0	8,401		192.01
192.02	19202	EDUCATION CENTER		347	0	347		192.02
192.03	19203	MARKETING		0	0	0		192.03
193.00	19300	NONPAID WORKERS		0	0	0		193.00
194.00	07950	FOUNDATION		2,440	0	2,440		194.00
194.01	07951	GIFT SHOP		13,948	0	13,948		194.01
194.02	07952	CLINIC OF HOPE		8,294	0	8,294		194.02
200.00		Cross Foot Adjustments	22,521	22,521	0	22,521		200.00
201.00		Negative Cost Centers	0	79,623	0	79,623		201.00
202.00		TOTAL (sum lines 118 through 201)	22,521	8,656,807	0	8,656,807		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/21/2023 1:47 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	331,432					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,307,094				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,820	0	34,463,068			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	50,113	32,295	1,390,021	-31,513,403	101,713,032	5.00
7.00	00700	OPERATION OF PLANT	45,990	50,021	0	0	5,363,485	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	518	0	0	0	855,705	8.00
9.00	00900	HOUSEKEEPING	2,015	0	0	0	1,260,166	9.00
10.00	01000	DIETARY	5,205	10,558	0	0	1,390,129	10.00
11.00	01100	CAFETERIA	6,310	10,239	0	0	860,962	11.00
13.00	01300	NURSING ADMINISTRATION	5,461	123,597	1,833,052	0	2,848,827	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	72,941	198,756	87,745	0	14.00
15.00	01500	PHARMACY	3,199	6,568	1,746,606	0	2,646,077	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,447	2,144	0	0	27,221	16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	896	0	285,218	0	369,468	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,444	120,884	7,284,411	0	10,833,617	30.00
31.00	03100	INTENSIVE CARE UNIT	5,636	74,917	1,746,892	0	2,716,220	31.00
41.00	04100	SUBPROVIDER - IRF	13,568	462	1,237,961	0	1,787,408	41.00
43.00	04300	NURSERY	1,609	20,865	438,532	0	692,791	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,049	501,617	3,058,172	0	7,453,340	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,264	55,838	1,244,267	0	1,884,539	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,821	611,285	1,519,471	0	3,430,274	54.00
54.01	03630	ULTRA SOUND	0	97,404	334,919	0	547,195	54.01
56.00	05600	RADIOISOTOPE	2,000	455,104	660,165	0	1,694,877	56.00
57.00	05700	CT SCAN	0	0	774,413	0	1,051,589	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	222,082	340,999	0	691,317	58.00
60.00	06000	LABORATORY	7,900	2,805	0	0	6,452,363	60.00
65.00	06500	RESPIRATORY THERAPY	1,237	32,624	1,489,261	0	2,114,079	65.00
66.00	06600	PHYSICAL THERAPY	7,215	18,616	627,883	0	4,139,589	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,096	6,313	148,234	0	1,344,417	67.00
68.00	06800	SPEECH PATHOLOGY	1,040	849	19,940	0	187,190	68.00
69.00	06900	ELECTROCARDIOLOGY	4,003	119,422	341,480	0	661,985	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,728	16,262	542,963	0	833,138	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,309	1,715	0	0	1,459,298	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,757,136	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	16,200,372	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	314,149	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,591	11,560	880,418	0	1,205,489	76.00
76.01	03190	CHEMOTHERAPY	0	448,596	647,314	0	1,349,328	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	3,000	7,614	277,722	0	871,510	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	19,340	96,749	2,224,494	0	4,524,622	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,968	64,634	2,630,410	0	4,115,625	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	309,792	3,296,580	33,923,974	-31,425,658	97,935,497	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,431	1,986	384,969	0	3,514,083	192.00
192.01	19201	ASC MOB	0	7,675	0	0	11,098	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	15,179	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	180	0	0	0	1,832	194.00
194.01	07951	GIFT SHOP	1,029	0	0	0	10,474	194.01
194.02	07952	CLINIC OF HOPE	0	853	154,125	0	224,869	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,373,680	3,510,716	7,533,861		31,513,403	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.179102	1.061571	0.218607		0.309827	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			130,496		2,322,066	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003787		0.022830	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/21/2023 1:47 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
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: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/21/2023 1:47 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (ASSIGNED TIME)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	222,509					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	518	20,636				8.00
9.00	00900	HOUSEKEEPING	2,015	0	219,976			9.00
10.00	01000	DIETARY	5,205	0	5,205	20,636		10.00
11.00	01100	CAFETERIA	6,310	0	6,310	0	705,711	11.00
13.00	01300	NURSING ADMINISTRATION	5,461	0	5,461	0	47,385	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	8,857	14.00
15.00	01500	PHARMACY	3,199	0	3,199	0	33,113	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,447	0	2,447	0	0	16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	896	0	896	0	6,589	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,444	13,616	29,444	13,616	185,612	30.00
31.00	03100	INTENSIVE CARE UNIT	5,636	2,145	5,636	2,145	42,021	31.00
41.00	04100	SUBPROVIDER - IRF	13,568	3,683	13,568	3,683	34,720	41.00
43.00	04300	NURSERY	1,609	1,192	1,609	1,192	9,548	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,049	0	33,049	0	62,926	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,264	0	3,264	0	28,487	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,821	0	23,821	0	39,024	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	5,127	54.01
56.00	05600	RADIOISOTOPE	2,000	0	2,000	0	16,991	56.00
57.00	05700	CT SCAN	0	0	0	0	14,219	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	7,226	58.00
60.00	06000	LABORATORY	7,900	0	7,900	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,237	0	1,237	0	35,548	65.00
66.00	06600	PHYSICAL THERAPY	7,215	0	7,215	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,096	0	3,096	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,040	0	1,040	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,003	0	4,003	0	7,681	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,728	0	2,728	0	14,669	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,309	0	4,309	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,591	0	4,591	0	26,637	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	0	17,040	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	3,000	0	3,000	0	7,896	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	19,340	0	19,340	0	50,503	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,968	0	3,968	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	200,869	20,636	198,336	20,636	701,819	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,431	0	20,431	0	0	192.00
192.01	19201	ASC MOB	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	180	0	180	0	0	194.00
194.01	07951	GIFT SHOP	1,029	0	1,029	0	0	194.01
194.02	07952	CLINIC OF HOPE	0	0	0	0	3,892	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,025,237	1,137,181	1,714,218	2,025,726	1,376,108	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	31.572822	55.106658	7.792750	98.164664	1.949960	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	643,686	26,307	55,110	112,288	114,590	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.892854	1.274811	0.250527	5.441365	0.162375	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: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/21/2023 1:47 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	ALLIED HEALTH RAD TECH PROGRAM (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	570,361					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	8,801,806				14.00
15.00	01500	PHARMACY	3,261	53,754	16,200,372			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29	0	662,982,687		16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	0	0	0	0	80,510,114	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	209,385	342,449	0	32,400,865	0	30.00
31.00	03100	INTENSIVE CARE UNIT	62,328	132,984	0	10,582,420	0	31.00
41.00	04100	SUBPROVIDER - IRF	47,440	22,970	0	8,329,010	0	41.00
43.00	04300	NURSERY	19,167	27,266	0	2,636,491	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	80,281	1,917,259	0	103,420,371	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	51,294	72,967	0	19,257,080	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,058	470,092	0	27,230,588	27,230,588	54.00
54.01	03630	ULTRA SOUND	0	11,205	0	7,123,983	7,123,983	54.01
56.00	05600	RADIOISOTOPE	3,092	61,088	0	26,691,426	26,691,426	56.00
57.00	05700	CT SCAN	0	4,760	0	16,116,544	16,116,544	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	16,092	0	3,347,573	3,347,573	58.00
60.00	06000	LABORATORY	96	3,128	0	92,545,346	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,603	76,526	0	15,967,522	0	65.00
66.00	06600	PHYSICAL THERAPY	0	12,098	0	13,637,350	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,103	0	5,214,251	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	552	0	851,738	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,353	34,090	0	16,025,803	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	53,737	0	7,413,735	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,282,468	0	19,506,483	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,757,136	0	16,881,765	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	16,200,372	82,770,971	0	73.00
74.00	07400	RENAL DIALYSIS	0	2,569	0	1,738,438	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,076	48	0	2,321,912	0	76.00
76.01	03190	CHEMOTHERAPY	13,205	33,667	0	8,998,237	0	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	4,614	65,705	0	13,473,437	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	62,020	270,875	0	85,846,551	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	69,276	0	22,652,797	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	568,273	8,798,893	16,200,372	662,982,687	80,510,114	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	ASC MOB	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	0	10	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	GIFT SHOP	0	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	2,088	2,903	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,038,845	-70,474	3,679,494	131,983	532,058	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.081208	0.000000	0.227124	0.000199	0.006609	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	283,636	79,623	123,613	35,497	22,521	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.497292	0.009046	0.007630	0.000054	0.000280	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/21/2023 1:47 pm

	Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	ALLIED HEALTH RAD TECH PROGRAM (ASSIGNED TIME)	
		13.00	14.00	15.00	16.00	23.00	
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: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/21/2023 1:47 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,287,269		19,287,269	0	19,287,269	30.00
31.00	03100	INTENSIVE CARE UNIT	4,633,812		4,633,812	0	4,633,812	31.00
41.00	04100	SUBPROVIDER - IRF	3,845,098		3,845,098	0	3,845,098	41.00
43.00	04300	NURSERY	1,308,344		1,308,344	0	1,308,344	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,775,396		11,775,396	27,348	11,802,744	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,019,514		3,019,514	0	3,019,514	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,706,814		5,706,814	0	5,706,814	54.00
54.01	03630	ULTRA SOUND	775,228		775,228	0	775,228	54.01
56.00	05600	RADIOISOTOPE	2,535,471		2,535,471	0	2,535,471	56.00
57.00	05700	CT SCAN	1,514,847		1,514,847	0	1,514,847	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	942,386		942,386	0	942,386	58.00
60.00	06000	LABORATORY	8,781,564		8,781,564	0	8,781,564	60.00
65.00	06500	RESPIRATORY THERAPY	2,915,783	0	2,915,783	0	2,915,783	65.00
66.00	06600	PHYSICAL THERAPY	5,708,882	0	5,708,882	0	5,708,882	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,883,867	0	1,883,867	0	1,883,867	67.00
68.00	06800	SPEECH PATHOLOGY	286,296	0	286,296	0	286,296	68.00
69.00	06900	ELECTROCARDIOLOGY	1,073,657		1,073,657	0	1,073,657	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,228,736		1,228,736	0	1,228,736	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,084,936		2,084,936	0	2,084,936	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,924,557		4,924,557	0	4,924,557	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,915,609		24,915,609	0	24,915,609	73.00
74.00	07400	RENAL DIALYSIS	411,827		411,827	0	411,827	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,826,814		1,826,814	0	1,826,814	76.00
76.01	03190	CHEMOTHERAPY	1,895,911		1,895,911	0	1,895,911	76.01
76.02	03330	ENDOSCOPY	0		0	0	0	76.02
76.03	03950	WOUND CARE CENTER	1,310,374		1,310,374	0	1,310,374	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,242,541		7,242,541	0	7,242,541	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,297,448		1,297,448		1,297,448	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,551,468		5,551,468	0	5,551,468	95.00
200.00		Subtotal (see instructions)	128,684,449	0	128,684,449	27,348	128,711,797	200.00
201.00		Less Observation Beds	1,297,448		1,297,448		1,297,448	201.00
202.00		Total (see instructions)	127,387,001	0	127,387,001	27,348	127,414,349	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/21/2023 1:47 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,743,351		29,743,351			30.00
31.00	03100	INTENSIVE CARE UNIT	10,582,420		10,582,420			31.00
41.00	04100	SUBPROVIDER - IRF	8,329,010		8,329,010			41.00
43.00	04300	NURSERY	2,636,491		2,636,491			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,088,334	76,332,037	103,420,371	0.113860	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,256,850	1,000,230	19,257,080	0.156800	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,498,687	24,731,901	27,230,588	0.209574	0.000000	54.00
54.01	03630	ULTRA SOUND	1,650,489	5,473,494	7,123,983	0.108819	0.000000	54.01
56.00	05600	RADIOISOTOPE	453,339	26,238,087	26,691,426	0.094992	0.000000	56.00
57.00	05700	CT SCAN	4,248,930	11,867,614	16,116,544	0.093993	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	731,465	2,616,108	3,347,573	0.281513	0.000000	58.00
60.00	06000	LABORATORY	34,286,929	58,258,417	92,545,346	0.094889	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	9,735,177	6,232,345	15,967,522	0.182607	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,411,918	10,225,432	13,637,350	0.418621	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,390,188	1,824,063	5,214,251	0.361292	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	620,462	231,276	851,738	0.336132	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,329,644	12,696,159	16,025,803	0.066996	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	417,820	6,995,915	7,413,735	0.165738	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,156,681	11,349,802	19,506,483	0.106884	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,408,108	9,473,657	16,881,765	0.291709	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,154,847	66,616,124	82,770,971	0.301019	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,353,774	384,664	1,738,438	0.236895	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,984	2,319,928	2,321,912	0.786771	0.000000	76.00
76.01	03190	CHEMOTHERAPY	62,182	8,936,055	8,998,237	0.210698	0.000000	76.01
76.02	03330	ENDOSCOPY	0	0	0	0.000000	0.000000	76.02
76.03	03950	WOUND CARE CENTER	70,707	13,402,730	13,473,437	0.097256	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	18,914,958	66,931,593	85,846,551	0.084366	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	485,913	2,171,601	2,657,514	0.488219	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	14,518	22,638,279	22,652,797	0.245068	0.000000	95.00
200.00		Subtotal (see instructions)	214,035,176	448,947,511	662,982,687			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	214,035,176	448,947,511	662,982,687			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/21/2023 1:47 pm

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	0.114124	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.156800	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209574	54.00
54.01	03630	ULTRA SOUND	0.108819	54.01
56.00	05600	RADIOISOTOPE	0.094992	56.00
57.00	05700	CT SCAN	0.093993	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.281513	58.00
60.00	06000	LABORATORY	0.094889	60.00
65.00	06500	RESPIRATORY THERAPY	0.182607	65.00
66.00	06600	PHYSICAL THERAPY	0.418621	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.361292	67.00
68.00	06800	SPEECH PATHOLOGY	0.336132	68.00
69.00	06900	ELECTROCARDIOLOGY	0.066996	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.165738	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.106884	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.291709	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.301019	73.00
74.00	07400	RENAL DIALYSIS	0.236895	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.786771	76.00
76.01	03190	CHEMOTHERAPY	0.210698	76.01
76.02	03330	ENDOSCOPY	0.000000	76.02
76.03	03950	WOUND CARE CENTER	0.097256	76.03
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.084366	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.488219	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.245068	95.00
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: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/21/2023 1:47 pm

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	19,287,269		19,287,269	0	19,287,269	30.00
31.00	03100	INTENSIVE CARE UNIT	4,633,812		4,633,812	0	4,633,812	31.00
41.00	04100	SUBPROVIDER - IRF	3,845,098		3,845,098	0	3,845,098	41.00
43.00	04300	NURSERY	1,308,344		1,308,344	0	1,308,344	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,775,396		11,775,396	27,348	11,802,744	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,019,514		3,019,514	0	3,019,514	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,706,814		5,706,814	0	5,706,814	54.00
54.01	03630	ULTRA SOUND	775,228		775,228	0	775,228	54.01
56.00	05600	RADIOISOTOPE	2,535,471		2,535,471	0	2,535,471	56.00
57.00	05700	CT SCAN	1,514,847		1,514,847	0	1,514,847	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	942,386		942,386	0	942,386	58.00
60.00	06000	LABORATORY	8,781,564		8,781,564	0	8,781,564	60.00
65.00	06500	RESPIRATORY THERAPY	2,915,783	0	2,915,783	0	2,915,783	65.00
66.00	06600	PHYSICAL THERAPY	5,708,882	0	5,708,882	0	5,708,882	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,883,867	0	1,883,867	0	1,883,867	67.00
68.00	06800	SPEECH PATHOLOGY	286,296	0	286,296	0	286,296	68.00
69.00	06900	ELECTROCARDIOLOGY	1,073,657		1,073,657	0	1,073,657	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,228,736		1,228,736	0	1,228,736	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,084,936		2,084,936	0	2,084,936	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,924,557		4,924,557	0	4,924,557	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,915,609		24,915,609	0	24,915,609	73.00
74.00	07400	RENAL DIALYSIS	411,827		411,827	0	411,827	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,826,814		1,826,814	0	1,826,814	76.00
76.01	03190	CHEMOTHERAPY	1,895,911		1,895,911	0	1,895,911	76.01
76.02	03330	ENDOSCOPY	0		0	0	0	76.02
76.03	03950	WOUND CARE CENTER	1,310,374		1,310,374	0	1,310,374	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,242,541		7,242,541	0	7,242,541	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,297,448		1,297,448		1,297,448	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,551,468		5,551,468	0	5,551,468	95.00
200.00		Subtotal (see instructions)	128,684,449	0	128,684,449	27,348	128,711,797	200.00
201.00		Less Observation Beds	1,297,448		1,297,448		1,297,448	201.00
202.00		Total (see instructions)	127,387,001	0	127,387,001	27,348	127,414,349	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/21/2023 1:47 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,743,351		29,743,351			30.00
31.00	03100	INTENSIVE CARE UNIT	10,582,420		10,582,420			31.00
41.00	04100	SUBPROVIDER - IRF	8,329,010		8,329,010			41.00
43.00	04300	NURSERY	2,636,491		2,636,491			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,088,334	76,332,037	103,420,371	0.113860	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,256,850	1,000,230	19,257,080	0.156800	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,498,687	24,731,901	27,230,588	0.209574	0.000000	54.00
54.01	03630	ULTRA SOUND	1,650,489	5,473,494	7,123,983	0.108819	0.000000	54.01
56.00	05600	RADIOISOTOPE	453,339	26,238,087	26,691,426	0.094992	0.000000	56.00
57.00	05700	CT SCAN	4,248,930	11,867,614	16,116,544	0.093993	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	731,465	2,616,108	3,347,573	0.281513	0.000000	58.00
60.00	06000	LABORATORY	34,286,929	58,258,417	92,545,346	0.094889	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	9,735,177	6,232,345	15,967,522	0.182607	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,411,918	10,225,432	13,637,350	0.418621	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,390,188	1,824,063	5,214,251	0.361292	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	620,462	231,276	851,738	0.336132	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,329,644	12,696,159	16,025,803	0.066996	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	417,820	6,995,915	7,413,735	0.165738	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,156,681	11,349,802	19,506,483	0.106884	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,408,108	9,473,657	16,881,765	0.291709	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,154,847	66,616,124	82,770,971	0.301019	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,353,774	384,664	1,738,438	0.236895	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,984	2,319,928	2,321,912	0.786771	0.000000	76.00
76.01	03190	CHEMOTHERAPY	62,182	8,936,055	8,998,237	0.210698	0.000000	76.01
76.02	03330	ENDOSCOPY	0	0	0	0.000000	0.000000	76.02
76.03	03950	WOUND CARE CENTER	70,707	13,402,730	13,473,437	0.097256	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	18,914,958	66,931,593	85,846,551	0.084366	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	485,913	2,171,601	2,657,514	0.488219	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	14,518	22,638,279	22,652,797	0.245068	0.000000	95.00
200.00		Subtotal (see instructions)	214,035,176	448,947,511	662,982,687			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	214,035,176	448,947,511	662,982,687			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/21/2023 1:47 pm

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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630	ULTRA SOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
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
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
76.01	03190	CHEMOTHERAPY	0.000000		76.01
76.02	03330	ENDOSCOPY	0.000000		76.02
76.03	03950	WOUND CARE CENTER	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS			
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
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: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part I Date/Time Prepared: 11/21/2023 1:47 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,022,957	0	1,022,957	14,598	70.08	30.00
31.00	INTENSIVE CARE UNIT	276,036		276,036	2,145	128.69	31.00
41.00	SUBPROVIDER - IRF	281,160	0	281,160	3,683	76.34	41.00
43.00	NURSERY	80,293		80,293	1,192	67.36	43.00
200.00	Total (lines 30 through 199)	1,660,446		1,660,446	21,618		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	4,348	304,708	30.00
31.00	INTENSIVE CARE UNIT	572	73,611	31.00
41.00	SUBPROVIDER - IRF	1,858	141,840	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	6,778	520,159	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 11/21/2023 1:47 pm

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		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	1,209,958	103,420,371	0.011699	8,743,420	102,289	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	181,671	19,257,080	0.009434	55,124	520	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,059,174	27,230,588	0.038896	795,112	30,927	54.00
54.01	03630	ULTRA SOUND	118,378	7,123,983	0.016617	419,516	6,971	54.01
56.00	05600	RADIOISOTOPE	556,702	26,691,426	0.020857	54,815	1,143	56.00
57.00	05700	CT SCAN	30,120	16,116,544	0.001869	1,414,830	2,644	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	254,184	3,347,573	0.075931	192,850	14,643	58.00
60.00	06000	LABORATORY	260,578	92,545,346	0.002816	10,137,449	28,547	60.00
65.00	06500	RESPIRATORY THERAPY	113,443	15,967,522	0.007105	2,168,460	15,407	65.00
66.00	06600	PHYSICAL THERAPY	213,505	13,637,350	0.015656	738,319	11,559	66.00
67.00	06700	OCCUPATIONAL THERAPY	79,484	5,214,251	0.015244	498,238	7,595	67.00
68.00	06800	SPEECH PATHOLOGY	19,153	851,738	0.022487	129,949	2,922	68.00
69.00	06900	ELECTROCARDIOLOGY	200,788	16,025,803	0.012529	1,927,341	24,148	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	77,466	7,413,735	0.010449	163,540	1,709	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	93,597	19,506,483	0.004798	2,546,207	12,217	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	86,687	16,881,765	0.005135	2,108,691	10,828	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	497,894	82,770,971	0.006015	4,614,968	27,759	73.00
74.00	07400	RENAL DIALYSIS	7,266	1,738,438	0.004180	389,418	1,628	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	109,772	2,321,912	0.047277	0	0	76.00
76.01	03190	CHEMOTHERAPY	519,293	8,998,237	0.057711	3,348	193	76.01
76.02	03330	ENDOSCOPY	0	0	0.000000	0	0	76.02
76.03	03950	WOUND CARE CENTER	73,305	13,473,437	0.005441	58,560	319	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	515,762	85,846,551	0.006008	6,019,039	36,162	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	68,814	2,657,514	0.025894	103,790	2,688	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	6,346,994	589,038,618		43,282,984	342,818	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part III Date/Time Prepared: 11/21/2023 1:47 pm

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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	
			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	14,598	0.00	4,348	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,145	0.00	572	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	3,683	0.00	1,858	41.00
43.00	04300	NURSERY		0	1,192	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	21,618		6,778	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: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/21/2023 1:47 pm

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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	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	179,934	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	47,082	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	176,404	56.00
57.00	05700	CT SCAN	0	0	0	0	106,514	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	22,124	58.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	532,058	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/21/2023 1:47 pm

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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	103,420,371	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	19,257,080	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	179,934	179,934	27,230,588	0.006608	54.00
54.01	03630	ULTRA SOUND	0	47,082	47,082	7,123,983	0.006609	54.01
56.00	05600	RADIOISOTOPE	0	176,404	176,404	26,691,426	0.006609	56.00
57.00	05700	CT SCAN	0	106,514	106,514	16,116,544	0.006609	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	22,124	22,124	3,347,573	0.006609	58.00
60.00	06000	LABORATORY	0	0	0	92,545,346	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	15,967,522	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,637,350	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,214,251	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	851,738	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	16,025,803	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	7,413,735	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	19,506,483	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	16,881,765	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	82,770,971	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,738,438	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	2,321,912	0.000000	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	8,998,237	0.000000	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0.000000	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	13,473,437	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	85,846,551	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,657,514	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	532,058	532,058	589,038,618		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/21/2023 1:47 pm

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		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	8,743,420	0	17,887,915	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	55,124	0	1,427	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.006608	795,112	5,254	2,701,704	17,853	54.00
54.01	03630	ULTRA SOUND	0.006609	419,516	2,773	916,298	6,056	54.01
56.00	05600	RADIOISOTOPE	0.006609	54,815	362	8,857,093	58,537	56.00
57.00	05700	CT SCAN	0.006609	1,414,830	9,351	2,540,255	16,789	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.006609	192,850	1,275	578,524	3,823	58.00
60.00	06000	LABORATORY	0.000000	10,137,449	0	6,072,066	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,168,460	0	118,048	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	738,319	0	29,784	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	498,238	0	7,707	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	129,949	0	5,219	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,927,341	0	5,387,159	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	163,540	0	155,514	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,546,207	0	2,239,578	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,108,691	0	2,779,294	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,614,968	0	15,738,594	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	389,418	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	36,750	0	76.00
76.01	03190	CHEMOTHERAPY	0.000000	3,348	0	2,212,272	0	76.01
76.02	03330	ENDOSCOPY	0.000000	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.000000	58,560	0	4,387,915	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	6,019,039	0	10,912,093	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	103,790	0	1,522,822	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		43,282,984	19,015	85,088,031	103,058	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/21/2023 1:47 pm

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		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.113860	17,887,915	0	0	2,036,718	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.156800	1,427	0	0	224	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209574	2,701,704	0	0	566,207	54.00
54.01	03630	ULTRA SOUND	0.108819	916,298	0	0	99,711	54.01
56.00	05600	RADIOISOTOPE	0.094992	8,857,093	0	0	841,353	56.00
57.00	05700	CT SCAN	0.093993	2,540,255	0	0	238,766	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.281513	578,524	0	0	162,862	58.00
60.00	06000	LABORATORY	0.094889	6,072,066	0	0	576,172	60.00
65.00	06500	RESPIRATORY THERAPY	0.182607	118,048	0	0	21,556	65.00
66.00	06600	PHYSICAL THERAPY	0.418621	29,784	0	0	12,468	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.361292	7,707	0	0	2,784	67.00
68.00	06800	SPEECH PATHOLOGY	0.336132	5,219	0	0	1,754	68.00
69.00	06900	ELECTROCARDIOLOGY	0.066996	5,387,159	0	0	360,918	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.165738	155,514	0	0	25,775	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.106884	2,239,578	0	0	239,375	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.291709	2,779,294	0	0	810,745	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.301019	15,738,594	0	3,693	4,737,616	73.00
74.00	07400	RENAL DIALYSIS	0.236895	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.786771	36,750	0	0	28,914	76.00
76.01	03190	CHEMOTHERAPY	0.210698	2,212,272	0	0	466,121	76.01
76.02	03330	ENDOSCOPY	0.000000	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.097256	4,387,915	0	0	426,751	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.084366	10,912,093	0	0	920,610	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.488219	1,522,822	0	0	743,471	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.245068		0			95.00
200.00		Subtotal (see instructions)		85,088,031	0	3,693	13,320,871	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		85,088,031	0	3,693	13,320,871	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/21/2023 1:47 pm

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		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
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	1,112		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
76.01	03190	CHEMOTHERAPY	0	0		76.01
76.02	03330	ENDOSCOPY	0	0		76.02
76.03	03950	WOUND CARE CENTER	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
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			95.00
200.00		Subtotal (see instructions)	0	1,112		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,112		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 11/21/2023 1:47 pm

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	1,209,958	103,420,371	0.011699	35,471	415	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	181,671	19,257,080	0.009434	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,059,174	27,230,588	0.038896	76,229	2,965	54.00
54.01	03630	ULTRA SOUND	118,378	7,123,983	0.016617	0	0	54.01
56.00	05600	RADIOISOTOPE	556,702	26,691,426	0.020857	0	0	56.00
57.00	05700	CT SCAN	30,120	16,116,544	0.001869	46,280	86	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	254,184	3,347,573	0.075931	20,900	1,587	58.00
60.00	06000	LABORATORY	260,578	92,545,346	0.002816	1,084,162	3,053	60.00
65.00	06500	RESPIRATORY THERAPY	113,443	15,967,522	0.007105	172,981	1,229	65.00
66.00	06600	PHYSICAL THERAPY	213,505	13,637,350	0.015656	998,572	15,634	66.00
67.00	06700	OCCUPATIONAL THERAPY	79,484	5,214,251	0.015244	812,052	12,379	67.00
68.00	06800	SPEECH PATHOLOGY	19,153	851,738	0.022487	95,634	2,151	68.00
69.00	06900	ELECTROCARDIOLOGY	200,788	16,025,803	0.012529	68,384	857	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	77,466	7,413,735	0.010449	14,097	147	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	93,597	19,506,483	0.004798	191,763	920	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	86,687	16,881,765	0.005135	10,159	52	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	497,894	82,770,971	0.006015	389,278	2,342	73.00
74.00	07400	RENAL DIALYSIS	7,266	1,738,438	0.004180	76,953	322	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	109,772	2,321,912	0.047277	0	0	76.00
76.01	03190	CHEMOTHERAPY	519,293	8,998,237	0.057711	0	0	76.01
76.02	03330	ENDOSCOPY	0	0	0.000000	0	0	76.02
76.03	03950	WOUND CARE CENTER	73,305	13,473,437	0.005441	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	515,762	85,846,551	0.006008	28,285	170	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,657,514	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	6,278,180	589,038,618		4,121,200	44,309	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/21/2023 1:47 pm

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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	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	179,934	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	47,082	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	176,404	56.00
57.00	05700	CT SCAN	0	0	0	0	106,514	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	22,124	58.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	532,058	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/21/2023 1:47 pm

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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	103,420,371	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	19,257,080	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	179,934	179,934	27,230,588	0.006608	54.00
54.01	03630	ULTRA SOUND	0	47,082	47,082	7,123,983	0.006609	54.01
56.00	05600	RADIOISOTOPE	0	176,404	176,404	26,691,426	0.006609	56.00
57.00	05700	CT SCAN	0	106,514	106,514	16,116,544	0.006609	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	22,124	22,124	3,347,573	0.006609	58.00
60.00	06000	LABORATORY	0	0	0	92,545,346	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	15,967,522	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,637,350	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,214,251	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	851,738	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	16,025,803	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	7,413,735	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	19,506,483	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	16,881,765	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	82,770,971	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,738,438	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	2,321,912	0.000000	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	8,998,237	0.000000	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0.000000	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	13,473,437	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	85,846,551	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,657,514	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	532,058	532,058	589,038,618		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/21/2023 1:47 pm

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		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	35,471	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.006608	76,229	504	0	0	54.00
54.01	03630	ULTRA SOUND	0.006609	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.006609	0	0	0	0	56.00
57.00	05700	CT SCAN	0.006609	46,280	306	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.006609	20,900	138	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,084,162	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	172,981	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	998,572	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	812,052	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	95,634	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	68,384	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	14,097	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	191,763	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	10,159	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	389,278	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	76,953	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.000000	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0.000000	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	28,285	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		4,121,200	948	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/21/2023 1:47 pm

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	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)	14,598	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,598	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)	13,616	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	4,348	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)	19,287,269	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)	19,287,269	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)	19,287,269	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)	1,321.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,744,708	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	5,744,708	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/21/2023 1:47 pm

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	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	4,633,812	2,145	2,160.29	572	1,235,686	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)	6,391,737	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)	13,372,131	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)	378,319	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	361,833	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	740,152	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	12,631,979	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)	982	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,321.23	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,297,448	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/21/2023 1:47 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,022,957	19,287,269	0.053038	1,297,448	68,814	90.00
91.00	Nursing Program cost	0	19,287,269	0.000000	1,297,448	0	91.00
92.00	Allied health cost	0	19,287,269	0.000000	1,297,448	0	92.00
93.00	All other Medical Education	0	19,287,269	0.000000	1,297,448	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/21/2023 1:47 pm
	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)	3,683	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,683	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)	3,683	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)	1,858	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)	3,845,098	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)	3,845,098	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)	3,845,098	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)	1,044.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,939,771	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)	1,939,771	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/21/2023 1:47 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	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)	1,076,450	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)	3,016,221	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)	141,840	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	45,257	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	187,097	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,829,124	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: 15-0010 Component CCN: 15-T010	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/21/2023 1:47 pm
	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	281,160	3,845,098	0.073122	0	0	90.00
91.00	Nursing Program cost	0	3,845,098	0.000000	0	0	91.00
92.00	Allied health cost	0	3,845,098	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,845,098	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/21/2023 1:47 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,598	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,598	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)	13,616	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)	226	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)	1,192	15.00
16.00	Nursery days (title V or XIX only)	62	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)	19,287,269	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)	19,287,269	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)	19,287,269	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)	1,321.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	298,598	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)	298,598	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/21/2023 1:47 pm

Title XIX | Hospital | 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)	1,308,344	1,192	1,097.60	62	68,051	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,633,812	2,145	2,160.29	210	453,661	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)	909,102	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,729,412	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)	982	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,321.23	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,297,448	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/21/2023 1:47 pm

Title XIX | Hospital | Cost

	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	1,022,957	19,287,269	0.053038	1,297,448	68,814	90.00
91.00	Nursing Program cost	0	19,287,269	0.000000	1,297,448	0	91.00
92.00	Allied health cost	0	19,287,269	0.000000	1,297,448	0	92.00
93.00	All other Medical Education	0	19,287,269	0.000000	1,297,448	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/21/2023 1:47 pm
	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)	3,683	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,683	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)	3,683	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)	53	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)	1,192	15.00
16.00	Nursery days (title V or XIX only)	62	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)	3,845,098	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)	3,845,098	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)	3,845,098	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)	1,044.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	55,333	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)	55,333	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/21/2023 1:47 pm

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)	33,216	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)	88,549	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: 15-0010 Component CCN: 15-T010	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/21/2023 1:47 pm
	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	281,160	3,845,098	0.073122	0	0	90.00
91.00	Nursing Program cost	0	3,845,098	0.000000	0	0	91.00
92.00	Allied health cost	0	3,845,098	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,845,098	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/21/2023 1:47 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		9,761,226		30.00
31.00	03100	INTENSIVE CARE UNIT		2,968,400		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	0.114124	8,743,420	997,834	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.156800	55,124	8,643	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209574	795,112	166,635	54.00
54.01	03630	ULTRA SOUND	0.108819	419,516	45,651	54.01
56.00	05600	RADIOISOTOPE	0.094992	54,815	5,207	56.00
57.00	05700	CT SCAN	0.093993	1,414,830	132,984	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.281513	192,850	54,290	58.00
60.00	06000	LABORATORY	0.094889	10,137,449	961,932	60.00
65.00	06500	RESPIRATORY THERAPY	0.182607	2,168,460	395,976	65.00
66.00	06600	PHYSICAL THERAPY	0.418621	738,319	309,076	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.361292	498,238	180,009	67.00
68.00	06800	SPEECH PATHOLOGY	0.336132	129,949	43,680	68.00
69.00	06900	ELECTROCARDIOLOGY	0.066996	1,927,341	129,124	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.165738	163,540	27,105	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.106884	2,546,207	272,149	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.291709	2,108,691	615,124	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.301019	4,614,968	1,389,193	73.00
74.00	07400	RENAL DIALYSIS	0.236895	389,418	92,251	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.786771	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.210698	3,348	705	76.01
76.02	03330	ENDOSCOPY	0.000000	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.097256	58,560	5,695	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.084366	6,019,039	507,802	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.488219	103,790	50,672	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)		43,282,984	6,391,737	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)		43,282,984		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/21/2023 1:47 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF		4,188,120		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.114124	35,471	4,048	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.156800	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209574	76,229	15,976	54.00
54.01	03630	ULTRA SOUND	0.108819	0	0	54.01
56.00	05600	RADIOISOTOPE	0.094992	0	0	56.00
57.00	05700	CT SCAN	0.093993	46,280	4,350	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.281513	20,900	5,884	58.00
60.00	06000	LABORATORY	0.094889	1,084,162	102,875	60.00
65.00	06500	RESPIRATORY THERAPY	0.182607	172,981	31,588	65.00
66.00	06600	PHYSICAL THERAPY	0.418621	998,572	418,023	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.361292	812,052	293,388	67.00
68.00	06800	SPEECH PATHOLOGY	0.336132	95,634	32,146	68.00
69.00	06900	ELECTROCARDIOLOGY	0.066996	68,384	4,581	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.165738	14,097	2,336	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.106884	191,763	20,496	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.291709	10,159	2,963	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.301019	389,278	117,180	73.00
74.00	07400	RENAL DIALYSIS	0.236895	76,953	18,230	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.786771	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.210698	0	0	76.01
76.02	03330	ENDOSCOPY	0.000000	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.097256	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.084366	28,285	2,386	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.488219	0	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)		4,121,200	1,076,450	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)		4,121,200		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/21/2023 1:47 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		937,489		30.00
31.00	03100	INTENSIVE CARE UNIT		301,482		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		267,670		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.113860	759,287	86,452	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.156800	748,061	117,296	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209574	110,735	23,207	54.00
54.01	03630	ULTRA SOUND	0.108819	74,896	8,150	54.01
56.00	05600	RADIOISOTOPE	0.094992	47	4	56.00
57.00	05700	CT SCAN	0.093993	226,760	21,314	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.281513	35,389	9,962	58.00
60.00	06000	LABORATORY	0.094889	1,525,732	144,775	60.00
65.00	06500	RESPIRATORY THERAPY	0.182607	319,472	58,338	65.00
66.00	06600	PHYSICAL THERAPY	0.418621	76,570	32,054	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.361292	9,191	3,321	67.00
68.00	06800	SPEECH PATHOLOGY	0.336132	4,175	1,403	68.00
69.00	06900	ELECTROCARDIOLOGY	0.066996	115,444	7,734	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.165738	17,081	2,831	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.106884	286,810	30,655	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.291709	260,489	75,987	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.301019	595,904	179,378	73.00
74.00	07400	RENAL DIALYSIS	0.236895	34,248	8,113	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.786771	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.210698	1,306	275	76.01
76.02	03330	ENDOSCOPY	0.000000	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.097256	3,977	387	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.084366	1,155,277	97,466	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.488219	0	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)		6,360,851	909,102	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)		6,360,851		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/21/2023 1:47 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF		114,995		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.113860	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.156800	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209574	342	72	54.00
54.01	03630	ULTRA SOUND	0.108819	0	0	54.01
56.00	05600	RADIOISOTOPE	0.094992	0	0	56.00
57.00	05700	CT SCAN	0.093993	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.281513	0	0	58.00
60.00	06000	LABORATORY	0.094889	21,462	2,037	60.00
65.00	06500	RESPIRATORY THERAPY	0.182607	5,272	963	65.00
66.00	06600	PHYSICAL THERAPY	0.418621	28,909	12,102	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.361292	26,579	9,603	67.00
68.00	06800	SPEECH PATHOLOGY	0.336132	637	214	68.00
69.00	06900	ELECTROCARDIOLOGY	0.066996	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.165738	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.106884	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.291709	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.301019	12,318	3,708	73.00
74.00	07400	RENAL DIALYSIS	0.236895	19,068	4,517	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.786771	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.210698	0	0	76.01
76.02	03330	ENDOSCOPY	0.000000	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.097256	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.084366	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.488219	0	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)		114,587	33,216	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)		114,587		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part A Date/Time Prepared: 11/21/2023 1:47 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	3,053,005	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	7,751,429	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)	37,718	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	13,485	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)	116.10	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 qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.94	30.00
31.00	Percentage of Medicaid patient days (see instructions)	24.41	31.00
32.00	Sum of lines 30 and 31	27.35	32.00
33.00	Allowable disproportionate share percentage (see instructions)	11.78	33.00
34.00	Disproportionate share adjustment (see instructions)	318,191	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E Part A Date/Time Prepared: 11/21/2023 1:47 pm

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		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)	0.000200783	0.000200349	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	1,444,031	1,377,280	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	363,975	1,030,130	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	1,394,105		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)	12,567,933		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)		12,567,933	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		857,791	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		3,830	53.00
54.00	Special add-on payments for new technologies		47,234	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 intructions)		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)		19,015	58.00
59.00	Total (sum of amounts on lines 49 through 58)		13,495,803	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		13,495,803	61.00
62.00	Deductibles billed to program beneficiaries		1,319,356	62.00
63.00	Coinsurance billed to program beneficiaries		78,181	63.00
64.00	Allowable bad debts (see instructions)		86,867	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		56,464	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		30,785	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		12,154,730	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)		0	70.75
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		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)		-10,871	70.94
70.95	Recovery of accelerated depreciation		0	70.95

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		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)		12,143,859	71.00
71.01	Sequestration adjustment (see instructions)		242,877	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		11,503,019	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)		397,963	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		236,437	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/21/2023 1:47 pm

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		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	3,053,005	0	3,053,005		3,053,005	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,751,429	0		7,751,429	7,751,429	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	37,718	0	37,718		37,718	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	13,485	0		13,485	13,485	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	0.1178	0.1178	0.1178	0.1178		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	318,191	0	89,911	228,280	318,191	11.00
11.01	Uncompensated care payments	36.00	1,394,105	0	363,975	1,030,130	1,394,105	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	12,567,933	0	3,544,609	9,023,324	12,567,933	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	12,567,933	0	3,544,609	9,023,324	12,567,933	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	857,791	0	244,024	613,767	857,791	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/21/2023 1:47 pm

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		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	47,234	0	20,779	26,456	47,235	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	3,809,412	9,663,547	13,472,959	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	809,996	0	229,327	580,669	809,996	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	1,625	0	1,625	0	1,625	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	0.0570	0.0570	0.0570	0.0570		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	46,170	0	13,072	33,098	46,170	25.00
26.00	Total prospective capital payments (see instructions)	12.00	857,791	0	244,024	613,767	857,791	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

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/21/2023 1:47 pm

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		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	3,053,005	3,053,005		3,053,005	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,751,429		7,751,429	7,751,429	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	37,718	37,718		37,718	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	13,485		13,485	13,485	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	0.1178	0.1178	0.1178		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	318,191	89,911	228,280	318,191	11.00
11.01	Uncompensated care payments	36.00	1,394,105	363,975	1,030,130	1,394,105	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	12,567,933	3,544,609	9,023,324	12,567,933	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	12,567,933	3,544,609	9,023,324	12,567,933	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	857,791	244,024	613,767	857,791	16.00
17.00	Special add-on payments for new technologies	54.00	47,234	20,779	26,455	47,234	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			3,809,412	9,663,546	13,472,958	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/21/2023 1:47 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	809,996	229,327	580,669	809,996	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	1,625	1,625	0	1,625	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	0.0570	0.0570	0.0570		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	46,170	13,072	33,098	46,170	25.00
26.00	Total prospective capital payments (see instructions)	12.00	857,791	244,024	613,767	857,791	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	-10,871	-1,537	-9,334	-10,871	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: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E Part B Date/Time Prepared: 11/21/2023 1:47 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,112	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	13,217,813	2.00
3.00	OPPS or REH payments	14,032,886	3.00
4.00	Outlier payment (see instructions)	80,586	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	103,058	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,112	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	3,693	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)	3,693	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	3,693	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	2,581	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)	1,112	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)	14,216,530	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)	2,485,957	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)	11,731,685	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	11,731,685	30.00
31.00	Primary payer payments	3,444	31.00
32.00	Subtotal (line 30 minus line 31)	11,728,241	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)	202,672	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	131,737	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	99,502	36.00
37.00	Subtotal (see instructions)	11,859,978	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-12	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	11,859,990	40.00
40.01	Sequestration adjustment (see instructions)	237,200	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	11,593,621	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	29,169	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	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: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/21/2023 1:47 pm
	Title XVIII	Hospital	PPS

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 11/21/2023 1:47 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		11,503,019		11,593,621	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)		11,503,019		11,593,621	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		397,963		29,169	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		11,900,982		11,622,790	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: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 11/21/2023 1:47 pm

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		3,332,747		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)		3,332,747		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		24,575		0	6.02
7.00	Total Medicare program liability (see instructions)		3,308,172		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet E-1 Part II Date/Time Prepared: 11/21/2023 1:47 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part III Date/Time Prepared: 11/21/2023 1:47 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	3,314,231	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0036	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	82,193	3.00
4.00	Outlier Payments	1,324	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)	10.090411	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)	3,397,748	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	3,397,748	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	3,397,748	19.00
20.00	Deductibles	20,448	20.00
21.00	Subtotal (line 19 minus line 20)	3,377,300	21.00
22.00	Coinsurance	4,000	22.00
23.00	Subtotal (line 21 minus line 22)	3,373,300	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	2,212	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	1,438	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	3,374,738	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)	948	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)	3,375,686	32.00
32.01	Sequestration adjustment (see instructions)	67,514	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	3,332,747	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)	-24,575	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	1,324	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: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 11/21/2023 1:47 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	1,729,412		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)	1,729,412	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)	1,729,412	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	6,360,851	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)	6,360,851	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)	6,360,851	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	4,631,439	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)	1,729,412	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	1,729,412	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)	1,729,412	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	1,729,412	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	1,729,412	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	1,729,412	0	40.00
41.00	Interim payments	1,729,412	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 11/21/2023 1:47 pm
	Title XIX	Subprovider - IRF	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	88,549		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)	88,549	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)	88,549	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	114,587	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)	114,587	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)	114,587	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	26,038	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)	88,549	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	88,549	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)	88,549	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	88,549	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	88,549	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	88,549	0	40.00
41.00	Interim payments	88,549	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

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet E-5 Date/Time Prepared: 11/21/2023 1:47 pm
	Title XVIII		PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR		
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2	0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)	0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)	0	4.00
5.00	The rate used to calculate the time value of money (see instructions)	0.00	5.00
6.00	Time value of money for operating expenses (see instructions)	0	6.00
7.00	Time value of money for capital related expenses (see instructions)	0	7.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G | Date/Time Prepared: 11/21/2023 1:47 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	315,593	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	21,910,304	0	0	0	4.00
5.00	Other receivable	381,721	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,359,373	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	3,571,889	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)	28,538,880	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	525,279	0	0	0	12.00
13.00	Land improvements	2,316,541	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	89,006,541	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	653,423	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	20,718,982	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	2,210,983	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	43,132,559	0	0	0	23.00
24.00	Accumulated depreciation	0	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	-122,081,559	0	0	0	28.00
29.00	Minor equipment-nondepreciable	213,718	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	36,696,467	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	175,068	0	0	0	31.00
32.00	Deposits on leases	1,171,895	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	268,618	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,615,581	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	66,850,928	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,770,212	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,012,885	0	0	0	38.00
39.00	Payroll taxes payable	186,998	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	16,859,899	0	0	0	43.00
44.00	Other current liabilities	5,494,968	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	27,324,962	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	237,950	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	14,206,750	0	0	0	48.00
49.00	Other long term liabilities	3,062,411	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	17,507,111	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	44,832,073	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	22,018,855				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)	22,018,855	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	66,850,928	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-1 | Date/Time Prepared: 11/21/2023 1:47 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		12,660,652		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		15,107,482				2.00
3.00	Total (sum of line 1 and line 2)		27,768,134		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		27,768,134		0		11.00
12.00	TRANSFER TO ALPHA	5,750,033		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		5,750,033		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		22,018,101		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	TRANSFER TO ALPHA		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/21/2023 1:47 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	32,865,682		32,865,682	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	8,329,010		8,329,010	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)	41,194,692		41,194,692	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	10,582,420		10,582,420	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)	10,582,420		10,582,420	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	51,777,112		51,777,112	17.00
18.00	Ancillary services	162,212,212	1,518	162,213,730	18.00
19.00	Outpatient services	0	408,447,121	408,447,121	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	14,518	22,638,279	22,652,797	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	597,105	2,527,653	3,124,758	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	214,600,947	433,614,571	648,215,518	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		154,363,526		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)		154,363,526		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-3 | Date/Time Prepared: 11/21/2023 1:47 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	648,215,518	1.00
2.00	Less contractual allowances and discounts on patients' accounts	481,034,396	2.00
3.00	Net patient revenues (line 1 minus line 2)	167,181,122	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	154,363,526	4.00
5.00	Net income from service to patients (line 3 minus line 4)	12,817,596	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	425,154	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	632	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	1,779	21.00
22.00	Rental of hospital space	399,543	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS REVENUE	4,865	24.00
24.01	CONTRACT SERVICE REVENUE	0	24.01
24.02	FOUNDATION IC TRANSFERS	17,935	24.02
24.03	IC RENTAL INCOME	124,596	24.03
24.04	OTHER (SPECIFY)	0	24.04
24.05	GAIN ON SALE OF ASSETS	36,863	24.05
24.06	PAIENT INTEREST INCOME	13,637	24.06
24.07	LATE PENALTY FEES	814	24.07
24.08	INDIANA NCLAIMED PROPERTY	177,338	24.08
24.09	MEDICAL STAFF DUES	9,420	24.09
24.10	RECYCLING REVENUE	428	24.10
24.11	UNITED HOSPITAL LAUNDRY INCOME	-7,999	24.11
24.12	CLINICAL TRIAL REVENE	6,000	24.12
24.13	VALUE BASED IC REVENUE	291,550	24.13
24.14	FEDERAL SPONSORED PRCT REV	521,870	24.14
24.15	NET ASSETS RLD RES FND	7,720	24.15
24.16	SCRAP REVENUE	86	24.16
24.17	STATE SPONSORED PROJECT REVENUE	61,374	24.17
24.18	OTHER (SPECIFY)	0	24.18
24.19	OTHER (SPECIFY)	0	24.19
24.20	MEALS ON WHEELS	75,130	24.20
24.21	SEMINAR REVENUE	25,278	24.21
24.22	OTHER (SPECIFY)	0	24.22
24.23	OTHER (SPECIFY)	0	24.23
24.50	COVID-19 PHE Funding	95,873	24.50
25.00	Total other income (sum of lines 6-24)	2,289,886	25.00
26.00	Total (line 5 plus line 25)	15,107,482	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	15,107,482	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet L Parts I-III Date/Time Prepared: 11/21/2023 1:47 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	809,996	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	1,625	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)	47.32	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)	2.94	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	24.41	8.00
9.00	Sum of lines 7 and 8	27.35	9.00
10.00	Allowable disproportionate share percentage (see instructions)	5.70	10.00
11.00	Disproportionate share adjustment (see instructions)	46,170	11.00
12.00	Total prospective capital payments (see instructions)	857,791	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