

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: 14-0101	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/31/2024 12:19 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 5/31/2024	Time: 12:19 pm
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MORRIS HOSPITAL (14-0101) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	Michael Lawrence	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	Michael Lawrence		2
3	Signatory Title	CHIEF FINANCIAL OFFICER		3
4	Date	(Dated when report is electronica		4

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	245,707	94,688	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	2.00
3.00	SUBPROVIDER - IRF	0	0	0	0	3.00
5.00	SWING BED - SNF	0	0	0	0	5.00
6.00	SWING BED - NF	0			0	6.00
200.00	TOTAL	0	245,707	94,688	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: 14-0101		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 12:19 pm				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 150 WEST HIGH STREET			PO Box:				1.00				
2.00	City: MORRIS			State: IL		Zip Code: 60450		County: GRUNDY				
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
								V	XVIII			
								XIX				
Hospital and Hospital-Based Component Identification:												
3.00	Hospital			MORRIS HOSPITAL	140101	16984	1	07/01/1966	0	P	P	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF			MORRIS HOSPITAL	14U101	16974		10/07/1994	N	N	N	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)						01/01/2023		12/31/2023		20.00	
21.00	Type of Control (see instructions)						2				21.00	
							1.00	2.00		3.00		
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N				22.00	
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	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)					N	N		N		22.03	
22.04	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.											
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)											
22.04	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.											
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N				23.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0101		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 12:19 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.	238	360	0	0	1,570	113	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00	
						Urban/Rural	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)					Y	Y	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	Y	40.00	
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR 412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 14-0101		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 12:19 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.			N					60.00	
			Y/N	IME	Direct GME	IME	Direct GME			
			1.00	2.00	3.00	4.00	5.00			
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)			N		0.00	0.00		61.00	
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)								61.01	
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)								61.02	
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)								61.03	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).								61.04	
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)								61.05	
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)								61.06	
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count				
			1.00	2.00	3.00	4.00				
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.					0.00	0.00		61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.					0.00	0.00		61.20	
							1.00			
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet S-2
Part I
Date/Time Prepared:
5/31/2024 12:19 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
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

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

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		V 1.00		XIX 2.00			
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N		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		N		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		N		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		N		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		N		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	
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)					107.01	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					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				0115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0101	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 12:19 pm
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1,715,445	50,000	0
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	Y		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	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.	Y	N	123.00
Certified Transplant Center Information				
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		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:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00
			1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y	144.00
		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0101		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 12:19 pm		
						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	
						1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
				Beginning	Ending			
				1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00
				1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0101		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part II Date/Time Prepared: 5/31/2024 12:19 pm	
				Y/N	Date		
				1.00	2.00		
PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE							
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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.	Y					5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/02/2024	Y	05/02/2024		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		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: 14-0101

Period:
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Date/Time Prepared:
5/31/2024 12:19 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?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
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.	ALEX	BLUMENSHINE		41.00
42.00	Enter the employer/company name of the cost report preparer.	MORRIS HOSPITAL & HEALTHCARE CENTERS			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815. 705. 7037	ABLUMENSHINE@MORRISHOSPITAL.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

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		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.	DIRECTOR OF REVENUE CYCLE	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: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part I
Date/Time Prepared:
5/31/2024 12:19 pm

Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	I/P Days / O/P	
	Line No.		Avai l a b l e	Hours	Vi s i t s / T r i p s	
	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	81	29,565	0.00	0
2.00	HMO and other (see instructions)					
3.00	HMO IPF Subprovider					
4.00	HMO IRF Subprovider					
5.00	Hospital Adults & Peds. Swing Bed SNF				0	
6.00	Hospital Adults & Peds. Swing Bed NF				0	
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		81	29,565	0.00	0
8.00	INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0
9.00	CORONARY CARE UNIT					
10.00	BURN INTENSIVE CARE UNIT					
11.00	SURGICAL INTENSIVE CARE UNIT					
12.00	OTHER SPECIAL CARE (SPECIFY)					
13.00	NURSERY	43.00				0
14.00	Total (see instructions)		89	32,485	0.00	0
15.00	CAH visits					0
15.10	REH hours and visits				0.00	0
16.00	SUBPROVIDER - IPF					
17.00	SUBPROVIDER - IRF					
18.00	SUBPROVIDER					
19.00	SKILLED NURSING FACILITY					
20.00	NURSING FACILITY					
21.00	OTHER LONG TERM CARE					
22.00	HOME HEALTH AGENCY					
23.00	AMBULATORY SURGICAL CENTER (D.P.)					
24.00	HOSPICE					
24.10	HOSPICE (non-distinct part)	30.00				
25.00	CMHC - CMHC					
26.00	RURAL HEALTH CLINIC					
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0
27.00	Total (sum of lines 14-26)		89			
28.00	Observation Bed Days					0
29.00	Ambulance Trips					
30.00	Employee discount days (see instruction)					
31.00	Employee discount days - IRF					
32.00	Labor & delivery days (see instructions)		0	0		
32.01	Total ancillary labor & delivery room outpatient days (see instructions)					
33.00	LTCH non-covered days					
33.01	LTCH site neutral days and discharges					
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part I
Date/Time Prepared:
5/31/2024 12:19 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)	5,550	490	11,608			1.00
2.00	HMO and other (see instructions)	2,266	1,570				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,550	490	11,608			7.00
8.00	INTENSIVE CARE UNIT	647	60	1,416			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		48	1,138			13.00
14.00	Total (see instructions)	6,197	598	14,162	0.00	1,182.33	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	1,182.33	27.00
28.00	Observation Bed Days		43	2,119			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			119			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	113	337			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: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part I
Date/Time Prepared:
5/31/2024 12:19 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	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	1,489	27	2,635	1.00
2.00 HMO and other (see instructions)			461	286		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,489	27	2,635	14.00
15.00 CAH visits						15.00
15.10 REH hours and visits						15.10
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01
34.00 Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part II
Date/Time Prepared:
5/31/2024 12:19 pm

		Wkst. A Line Number	Amount Reported	Recl assi fi cation 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	106,873,952	0	106,873,952	2,459,241.21	43.46	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		9,393,206	0	9,393,206	68,510.68	137.11	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)		17,918,390	0	17,918,390	291,314.25	61.51	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		2,426,036	0	2,426,036	25,472.05	95.24	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		0	0	0	0.00	0.00	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		0	0	0	0.00	0.00	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)		15,947,291	0	15,947,291			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		2,679,629	0	2,679,629			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		702,303	0	702,303			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: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part II
Date/Time Prepared:
5/31/2024 12:19 pm

		Wkst. A Line Number	Amount Reported	Recl assi fi cati on 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	1,453,436	0	1,453,436	18,743.75	77.54	26.00
27.00	Administrative & General	5.00	15,496,930	89,952	15,586,882	422,287.85	36.91	27.00
28.00	Administrative & General under contract (see inst.)		210,164	0	210,164	1,444.55	145.49	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,475,798	0	1,475,798	45,494.80	32.44	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	2,166,099	0	2,166,099	101,416.97	21.36	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,578,450	-1,043,223	535,227	23,485.44	22.79	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	953,271	953,271	41,720.87	22.85	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,065,605	0	1,065,605	27,192.17	39.19	38.00
39.00	Central Services and Supply	14.00	1,192,397	0	1,192,397	50,288.83	23.71	39.00
40.00	Pharmacy	15.00	2,386,103	0	2,386,103	43,515.37	54.83	40.00
41.00	Medical Records & Medical Records Library	16.00	1,678,487	0	1,678,487	58,408.45	28.74	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: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part III
Date/Time Prepared:
5/31/2024 12:19 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)	97,690,910	0	97,690,910	2,392,175.08	40.84	1.00
2.00	Excluded area salaries (see instructions)	17,918,390	0	17,918,390	291,314.25	61.51	2.00
3.00	Subtotal salaries (line 1 minus line 2)	79,772,520	0	79,772,520	2,100,860.83	37.97	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,426,036	0	2,426,036	25,472.05	95.24	4.00
5.00	Subtotal wage-related costs (see inst.)	15,947,291	0	15,947,291	0.00	19.99	5.00
6.00	Total (sum of lines 3 thru 5)	98,145,847	0	98,145,847	2,126,332.88	46.16	6.00
7.00	Total overhead cost (see instructions)	28,703,469	0	28,703,469	833,999.05	34.42	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part IV
Date/Time Prepared:
5/31/2024 12:19 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	2,075,852	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	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)	8,568,391	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	471,637	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	130,564	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	560,224	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	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	6,973,471	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	466,916	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	82,168	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	19,329,223	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: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part V
Date/Time Prepared:
5/31/2024 12:19 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	2,426,036	19,329,223	1.00
2.00	Hospital	2,426,036	19,329,223	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0101	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/31/2024 12:19 pm
				1.00
PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)		0.196215	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		10,994,634	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		902,475	5.00
6.00	Medicaid charges		127,048,092	6.00
7.00	Medicaid cost (line 1 times line 6)		24,928,741	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		13,031,632	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		13,031,632	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	7,157,974	4,669,097	11,827,071
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,404,502	4,669,097	6,073,599
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (see instructions)	1,404,502	4,669,097	6,073,599
				1.00
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
25.01	Charges for insured patients' liability (see instructions)		0	25.01
26.00	Bad debt amount (see instructions)		7,060,179	26.00
27.00	Medicare reimbursable bad debts (see instructions)		177,619	27.00
27.01	Medicare allowable bad debts (see instructions)		273,259	27.01
28.00	Non-Medicare bad debt amount (see instructions)		6,786,920	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		1,427,336	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		7,500,935	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		20,532,567	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0101	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/31/2024 12:19 pm
				1.00
PART II - HOSPITAL DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)		0.196215	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			5.00
6.00	Medicaid charges			6.00
7.00	Medicaid cost (line 1 times line 6)			7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)			8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP			9.00
10.00	Stand-alone CHIP charges			10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)			12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			14.00
15.00	State or local indigent care program cost (line 1 times line 14)			15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)			16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care			17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	7,157,974	4,669,097	11,827,071
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,404,502	4,669,097	6,073,599
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (see instructions)	1,404,502	4,669,097	6,073,599
				1.00
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
25.01	Charges for insured patients' liability (see instructions)		0	25.01
26.00	Bad debt amount (see instructions)		7,060,179	26.00
27.00	Medicare reimbursable bad debts (see instructions)		177,619	27.00
27.01	Medicare allowable bad debts (see instructions)		273,259	27.01
28.00	Non-Medicare bad debt amount (see instructions)		6,786,920	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		1,427,336	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		7,500,935	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		7,500,935	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0101

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

Worksheet A

Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		7,031,679	7,031,679	3,888,947	10,920,626	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,549,077	5,549,077	0	5,549,077	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,453,436	21,697,801	23,151,237	0	23,151,237	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,496,930	31,821,486	47,318,416	119,463	47,437,879	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,475,798	3,010,289	4,486,087	0	4,486,087	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	451,850	451,850	0	451,850	8.00
9.00	00900	HOUSEKEEPING	2,166,099	1,198,916	3,365,015	0	3,365,015	9.00
10.00	01000	DIETARY	1,578,450	780,222	2,358,672	-1,385,481	973,191	10.00
11.00	01100	CAFETERIA	0	0	0	1,266,018	1,266,018	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,065,605	12,781	1,078,386	0	1,078,386	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,192,397	17,653	1,210,050	0	1,210,050	14.00
15.00	01500	PHARMACY	2,386,103	11,313,213	13,699,316	0	13,699,316	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,678,487	182,250	1,860,737	0	1,860,737	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,147,039	1,587,971	11,735,010	-41,580	11,693,430	30.00
31.00	03100	INTENSIVE CARE UNIT	3,138,540	568,627	3,707,167	-1,558,641	2,148,526	31.00
43.00	04300	NURSERY	0	0	0	965,987	965,987	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,414,370	1,885,867	5,300,237	0	5,300,237	50.00
51.00	05100	RECOVERY ROOM	440,054	2,216	442,270	0	442,270	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	634,234	634,234	52.00
53.00	05300	ANESTHESIOLOGY	0	1,278,879	1,278,879	0	1,278,879	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,694,354	309,715	3,004,069	0	3,004,069	54.00
54.01	05401	NUCLEAR MEDICINE	348,964	322,562	671,526	0	671,526	54.01
54.02	05402	ULTRASOUND	994,331	73,053	1,067,384	0	1,067,384	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,120,887	1,030,865	2,151,752	0	2,151,752	55.00
57.00	05700	CT SCAN	887,570	160,275	1,047,845	0	1,047,845	57.00
58.00	05800	MRI	497,198	766,180	1,263,378	0	1,263,378	58.00
59.00	05900	CARDIAC CATHETERIZATION	790,159	588,542	1,378,701	0	1,378,701	59.00
59.97	05901	CARDIAC REHAB	334,798	11,144	345,942	0	345,942	59.97
60.00	06000	LABORATORY	4,335,505	5,335,534	9,671,039	0	9,671,039	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	969,486	552,441	1,521,927	0	1,521,927	65.00
66.00	06600	PHYSICAL THERAPY	2,262,394	131,455	2,393,849	0	2,393,849	66.00
67.00	06700	OCCUPATIONAL THERAPY	723,667	95,466	819,133	0	819,133	67.00
68.00	06800	SPEECH PATHOLOGY	168,539	4,175	172,714	0	172,714	68.00
69.00	06900	ELECTROCARDIOLOGY	927,042	137,970	1,065,012	0	1,065,012	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,873,336	6,873,336	0	6,873,336	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,214,813	5,214,813	0	5,214,813	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	21,697,817	3,381,776	25,079,593	0	25,079,593	90.00
91.00	09100	EMERGENCY	4,569,543	697,207	5,266,750	0	5,266,750	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		3,888,947	3,888,947	-3,888,947	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	88,955,562	117,966,233	206,921,795	0	206,921,795	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS	0	0	0	0	0	190.01
191.01	19101	PATIENT TRANSPORTATION	273,941	83,690	357,631	0	357,631	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	15,488,975	4,099,550	19,588,525	0	19,588,525	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	9,669	4,269	13,938	0	13,938	194.00
194.01	07951	MH HOSPITALIST	2,145,805	1,138,874	3,284,679	0	3,284,679	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	106,873,952	123,292,616	230,166,568	0	230,166,568	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0101

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

Worksheet A

Date/Time Prepared:
5/31/2024 12:19 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	-3,888,947	7,031,679	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	5,549,077	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-964,198	22,187,039	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-9,195,018	38,242,861	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-2,054	4,484,033	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	451,850	8.00
9.00	00900	HOUSEKEEPING	0	3,365,015	9.00
10.00	01000	DIETARY	0	973,191	10.00
11.00	01100	CAFETERIA	-400,591	865,427	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,078,386	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-2,516	1,207,534	14.00
15.00	01500	PHARMACY	-4,205	13,695,111	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-51,337	1,809,400	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-52,540	11,640,890	30.00
31.00	03100	INTENSIVE CARE UNIT	-900	2,147,626	31.00
43.00	04300	NURSERY	0	965,987	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-141,000	5,159,237	50.00
51.00	05100	RECOVERY ROOM	0	442,270	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	634,234	52.00
53.00	05300	ANESTHESIOLOGY	-1,272,790	6,089	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-60,000	2,944,069	54.00
54.01	05401	NUCLEAR MEDICINE	0	671,526	54.01
54.02	05402	ULTRASOUND	0	1,067,384	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	-472,952	1,678,800	55.00
57.00	05700	CT SCAN	0	1,047,845	57.00
58.00	05800	MRI	0	1,263,378	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,378,701	59.00
59.97	05901	CARDIAC REHAB	-3,288	342,654	59.97
60.00	06000	LABORATORY	-724,041	8,946,998	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-2,550	1,519,377	65.00
66.00	06600	PHYSICAL THERAPY	0	2,393,849	66.00
67.00	06700	OCCUPATIONAL THERAPY	-3,343	815,790	67.00
68.00	06800	SPEECH PATHOLOGY	0	172,714	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,065,012	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,873,336	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,214,813	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-9,153,515	15,926,078	90.00
91.00	09100	EMERGENCY	-582,606	4,684,144	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-26,978,391	179,943,404	118.00
NONREIMBURSABLE COST CENTERS					
190.01	19001	MEALS ON WHEELS	0	0	190.01
191.01	19101	PATIENT TRANSPORTATION	0	357,631	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	19,588,525	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	0	13,938	194.00
194.01	07951	MH HOSPITALIST	0	3,284,679	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-26,978,391	203,188,177	200.00

RECLASSIFICATIONS

Provider CCN: 14-0101

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

Worksheet A-6

Date/Time Prepared:
5/31/2024 12:19 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA FOOD SERVICE					
1.00	ADMINISTRATIVE & GENERAL	5.00	89,952	29,511	1.00
2.00	CAFETERIA	11.00	953,271	312,747	2.00
	TOTALS		1,043,223	342,258	
G - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,888,947	1.00
	TOTALS		0	3,888,947	
J - LDR & NURSERY					
1.00	NURSERY	43.00	814,072	151,915	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	534,492	99,742	2.00
	TOTALS		1,348,564	251,657	
K - POST ICU RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	1,199,919	358,722	1.00
	TOTALS		1,199,919	358,722	
500.00	Grand Total: Increases		3,591,706	4,841,584	500.00

RECLASSIFICATIONS

Provider CCN: 14-0101

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

Worksheet A-6

Date/Time Prepared:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA FOOD SERVICE						
1.00	DIETARY	10.00	1,043,223	342,258	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		1,043,223	342,258			
	G - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	3,888,947	11		1.00
	TOTALS		0	3,888,947			
	J - LDR & NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	1,348,564	251,657	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		1,348,564	251,657			
	K - POST ICU RECLASS						
1.00	INTENSIVE CARE UNIT	31.00	1,199,919	358,722	0		1.00
	TOTALS		1,199,919	358,722			
500.00	Grand Total: Decreases		3,591,706	4,841,584			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet A-7
Part I
Date/Time Prepared:
5/31/2024 12:19 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	11,231,824	0	0	0	253,542	1.00
2.00	Land Improvements	9,184,632	8,647	0	8,647	0	2.00
3.00	Buildings and Fixtures	132,355,416	0	0	0	20,226,662	3.00
4.00	Building Improvements	2,342,649	0	0	0	0	4.00
5.00	Fixed Equipment	47,102,234	8,155,195	0	8,155,195	0	5.00
6.00	Movable Equipment	92,055,294	13,575,612	0	13,575,612	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	294,272,049	21,739,454	0	21,739,454	20,480,204	8.00
9.00	Reconciling Items	30,812,575	0	0	0	27,243,690	9.00
10.00	Total (line 8 minus line 9)	263,459,474	21,739,454	0	21,739,454	-6,763,486	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	10,978,282	0				1.00
2.00	Land Improvements	9,193,279	0				2.00
3.00	Buildings and Fixtures	112,128,754	0				3.00
4.00	Building Improvements	2,342,649	0				4.00
5.00	Fixed Equipment	55,257,429	0				5.00
6.00	Movable Equipment	105,630,906	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	295,531,299	0				8.00
9.00	Reconciling Items	3,568,885	0				9.00
10.00	Total (line 8 minus line 9)	291,962,414	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet A-7
Part II
Date/Time Prepared:
5/31/2024 12:19 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	7,028,426	0	0	3,253	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,549,077	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	12,577,503	0	0	3,253	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	7,031,679				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,549,077				2.00
3.00	Total (sum of lines 1-2)	0	12,580,756				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet A-7
Part III
Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	186,331,508	0	186,331,508	0.638204	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	105,630,906	0	105,630,906	0.361796	0	2.00
3.00	Total (sum of lines 1-2)	291,962,414	0	291,962,414	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital -Related Costs	Total (sum of col.s. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	7,028,426	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	5,549,077	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,577,503	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital -Related Costs (see instructions)	Total (2) (sum of col.s. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	3,253	0	0	7,031,679	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	5,549,077	2.00
3.00	Total (sum of lines 1-2)	0	3,253	0	0	12,580,756	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0101

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

Worksheet A-8

Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	-3,888,947	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			OCAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)				0.00	0	3.00
4.00	Investment income - other (chapter 2)						
4.00	Trade, quantity, and time discounts (chapter 8)	B	-2,363	CENTRAL SERVICES & SUPPLY	14.00	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)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-13,776,815			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-153	CENTRAL SERVICES & SUPPLY	14.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-400,591	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	B	-4,205	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-51,337	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)	B	-162,180	EMERGENCY	91.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	OCAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	OCAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	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	LIFELINE SALARIES AND BENEFITS	A	-129,251	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0101

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

Worksheet A-8

Date/Time Prepared:
5/31/2024 12:19 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description			Cost Center	Line #	Wkst. A-7 Ref.	
1.00	2.00	3.00	4.00	5.00		
35.00 LOBBYING COSTS	A	-39,987	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00 MARKETING	A	-268,472	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00 MISC INCOME	B	-635,494	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00 EDUCATION SERVICES	B	-22,055	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00 VOLUNTEER SERVICES	B	-205	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00 MEALS ON WHEELS	B		MEALS ON WHEELS	190.01	0	40.00
41.00 MEDICAID PROVIDER TAXES	A	-6,545,581	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00 PHYSICIAN FRINGE BENEFITS	A	-471,007	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	42.00
43.00 MISC INCOME OBGYN	B	-540	ADULTS & PEDIATRICS	30.00	0	43.00
44.00 MISC INCOME ADMIN & GENERAL	B	-116,157	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00 MISC INCOME NURSING ADMIN	B		NURSING ADMINISTRATION	13.00	0	45.00
46.00 MISC INCOME CLINIC	B	-6,319	ADMINISTRATIVE & GENERAL	5.00	0	46.00
47.00 MH HCC ADMIN DEPOSITION FEES	B	-12,000	CLINIC	90.00	0	47.00
48.00 MH MAINT PLANT-BLD MISC INCOME	B	-2,054	OPERATION OF PLANT	7.00	0	48.00
49.00 MH VOLUNTARY BENEFITS MISC INCOME	B	-442,678	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-26,978,391				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0101

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

Worksheet A-8-2

Date/Time Prepared:
5/31/2024 12:19 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	50,513	50,513	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	9,153	9,153	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	900	900	0	0	0	3.00
4.00	55.00	RADIOLOGY-THERAPEUTIC	462,076	462,076	0	0	0	4.00
5.00	59.97	CARDIAC REHAB	3,288	3,288	0	0	0	5.00
6.00	60.00	LABORATORY	708,473	708,473	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	2,550	2,550	0	0	0	7.00
8.00	90.00	CLINIC	8,156,253	8,156,253	0	0	0	8.00
9.00	5.00	ADMINISTRATIVE & GENERAL	1,422,344	1,422,344	0	0	0	9.00
10.00	30.00	ADULTS & PEDIATRICS	52,000	52,000	0	0	0	10.00
11.00	50.00	OPERATING ROOM	141,000	141,000	0	0	0	11.00
12.00	53.00	ANESTHESIOLOGY	1,272,790	1,272,790	0	0	0	12.00
13.00	54.00	RADIOLOGY-DIAGNOSTIC	60,000	60,000	0	0	0	13.00
14.00	55.00	RADIOLOGY-THERAPEUTIC	10,876	10,876	0	0	0	14.00
15.00	60.00	LABORATORY	15,568	15,568	0	0	0	15.00
16.00	67.00	OCCUPATIONAL THERAPY	3,343	3,343	0	0	0	16.00
17.00	90.00	CLINIC	985,262	985,262	0	0	0	17.00
18.00	91.00	EMERGENCY	420,426	420,426	0	0	0	18.00
200.00			13,776,815	13,776,815	0	0	0	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	4.00
5.00	59.97	CARDIAC REHAB	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	9.00
10.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	10.00
11.00	50.00	OPERATING ROOM	0	0	0	0	0	11.00
12.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	12.00
13.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	13.00
14.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	14.00
15.00	60.00	LABORATORY	0	0	0	0	0	15.00
16.00	67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	16.00
17.00	90.00	CLINIC	0	0	0	0	0	17.00
18.00	91.00	EMERGENCY	0	0	0	0	0	18.00
200.00			0	0	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	50,513		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	9,153		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	900		3.00
4.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	462,076		4.00
5.00	59.97	CARDIAC REHAB	0	0	0	3,288		5.00
6.00	60.00	LABORATORY	0	0	0	708,473		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	2,550		7.00
8.00	90.00	CLINIC	0	0	0	8,156,253		8.00
9.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	1,422,344		9.00
10.00	30.00	ADULTS & PEDIATRICS	0	0	0	52,000		10.00
11.00	50.00	OPERATING ROOM	0	0	0	141,000		11.00
12.00	53.00	ANESTHESIOLOGY	0	0	0	1,272,790		12.00
13.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	60,000		13.00
14.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	10,876		14.00
15.00	60.00	LABORATORY	0	0	0	15,568		15.00
16.00	67.00	OCCUPATIONAL THERAPY	0	0	0	3,343		16.00
17.00	90.00	CLINIC	0	0	0	985,262		17.00
18.00	91.00	EMERGENCY	0	0	0	420,426		18.00
200.00			0	0	0	13,776,815		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part I
Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,031,679	7,031,679			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,549,077		5,549,077		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	22,187,039	49,488	39,054	22,275,581	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	38,242,861	1,339,069	1,056,731	3,611,713	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	4,484,033	842,664	664,992	342,162	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	451,850	0	0	0	8.00
9.00	00900	HOUSEKEEPING	3,365,015	201,891	159,323	502,208	9.00
10.00	01000	DIETARY	973,191	117,301	92,569	124,092	10.00
11.00	01100	CAFETERIA	865,427	60,200	47,507	221,015	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,078,386	14,387	11,354	247,059	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,207,534	65,660	51,816	276,456	14.00
15.00	01500	PHARMACY	13,695,111	79,391	62,652	553,216	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,809,400	3,465	2,735	389,156	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,640,890	536,100	423,065	2,318,118	30.00
31.00	03100	INTENSIVE CARE UNIT	2,147,626	181,255	143,038	449,259	31.00
43.00	04300	NURSERY	965,987	75,191	59,337	188,742	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,159,237	325,336	256,740	791,618	50.00
51.00	05100	RECOVERY ROOM	442,270	23,996	18,936	102,026	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	634,234	49,357	38,950	123,921	52.00
53.00	05300	ANESTHESIOLOGY	6,089	2,940	2,320	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,944,069	234,262	184,868	624,683	54.00
54.01	05401	NUCLEAR MEDICINE	671,526	27,356	21,588	80,907	54.01
54.02	05402	ULTRASOUND	1,067,384	8,322	6,568	230,535	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,678,800	87,241	68,847	152,745	55.00
57.00	05700	CT SCAN	1,047,845	81,649	64,434	205,782	57.00
58.00	05800	MRI	1,263,378	83,907	66,215	115,275	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,378,701	55,133	43,508	183,198	59.00
59.97	05901	CARDIAC REHAB	342,654	0	0	76,860	59.97
60.00	06000	LABORATORY	8,946,998	250,906	198,004	840,924	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,519,377	120,951	95,449	224,183	65.00
66.00	06600	PHYSICAL THERAPY	2,393,849	253,479	200,034	524,534	66.00
67.00	06700	OCCUPATIONAL THERAPY	815,790	0	0	167,781	67.00
68.00	06800	SPEECH PATHOLOGY	172,714	0	0	39,076	68.00
69.00	06900	ELECTROCARDIOLOGY	1,065,012	102,206	80,656	214,934	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,873,336	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,214,813	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	15,926,078	1,034,106	816,069	3,139,598	90.00
91.00	09100	EMERGENCY	4,684,144	165,739	130,794	1,059,444	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	179,943,404	6,472,948	5,108,153	18,121,220	118.00
NONREIMBURSABLE COST CENTERS							
190.01	19001	MEALS ON WHEELS	0	0	0	0	190.01
191.01	19101	PATIENT TRANSPORTATION	357,631	0	0	63,513	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	19,588,525	558,731	440,924	3,591,103	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	13,938	0	0	2,242	194.00
194.01	07951	MH HOSPITALIST	3,284,679	0	0	497,503	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	203,188,177	7,031,679	5,549,077	22,275,581	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part I
Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	44,250,374					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	1,763,426	0	8,097,277			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	125,801	0	0	577,651		8.00
9.00	00900	HOUSEKEEPING	1,177,252	0	340,544	0	5,746,233	9.00
10.00	01000	DIETARY	363,928	0	197,861	0	146,576	10.00
11.00	01100	CAFETERIA	332,467	0	101,543	0	75,224	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	376,188	0	24,268	0	17,978	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	445,869	0	110,754	0	82,047	14.00
15.00	01500	PHARMACY	4,006,466	0	133,915	0	99,205	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	613,833	0	5,845	0	4,330	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,153,413	0	904,278	473,476	669,895	30.00
31.00	03100	INTENSIVE CARE UNIT	813,294	0	305,736	57,757	226,491	31.00
43.00	04300	NURSERY	358,946	0	126,829	46,418	93,956	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,818,853	0	548,767	0	406,530	50.00
51.00	05100	RECOVERY ROOM	163,492	0	40,476	0	29,985	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	235,666	0	83,254	0	61,675	52.00
53.00	05300	ANESTHESIOLOGY	3,160	0	4,960	0	3,674	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,110,278	0	395,146	0	292,726	54.00
54.01	05401	NUCLEAR MEDICINE	223,114	0	46,144	0	34,184	54.01
54.02	05402	ULTRASOUND	365,503	0	14,038	0	10,399	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	553,383	0	147,156	0	109,014	55.00
57.00	05700	CT SCAN	389,697	0	137,723	0	102,026	57.00
58.00	05800	MRI	425,631	0	141,532	0	104,847	58.00
59.00	05900	CARDIAC CATHETERIZATION	462,316	0	92,996	0	68,892	59.00
59.97	05901	CARDIAC REHAB	116,798	0	0	0	0	59.97
60.00	06000	LABORATORY	2,850,067	0	423,222	0	313,525	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	545,678	0	204,016	0	151,136	65.00
66.00	06600	PHYSICAL THERAPY	938,780	0	427,562	0	316,740	66.00
67.00	06700	OCCUPATIONAL THERAPY	273,839	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	58,965	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	407,265	0	172,397	0	127,713	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,913,626	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,451,872	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,823,245	0	1,744,299	0	1,292,189	90.00
91.00	09100	EMERGENCY	1,681,648	0	279,565	0	207,103	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,343,759	0	7,154,826	577,651	5,048,060	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS	0	0	0	0	0	190.01
191.01	19101	PATIENT TRANSPORTATION	117,252	0	0	0	0	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	6,731,849	0	942,451	0	698,173	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	4,505	0	0	0	0	194.00
194.01	07951	MH HOSPITALIST	1,053,009	0	0	0	0	194.01
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)	44,250,374	0	8,097,277	577,651	5,746,233	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet B
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	2,015,518					10.00
11.00	01100	CAFETERIA	0	1,703,383				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	29,924	0	1,799,544		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	55,245	0	148	2,295,529	14.00
15.00	01500	PHARMACY	0	48,339	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	64,452	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,652,036	301,545	0	687,329	0	30.00
31.00	03100	INTENSIVE CARE UNIT	201,523	50,641	0	204,555	0	31.00
43.00	04300	NURSERY	161,959	20,717	0	89,389	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	87,471	0	237,723	0	50.00
51.00	05100	RECOVERY ROOM	0	9,207	0	38,749	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	13,811	0	58,691	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	78,264	0	42,622	0	54.00
54.01	05401	NUCLEAR MEDICINE	0	6,906	0	0	0	54.01
54.02	05402	ULTRASOUND	0	23,019	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	23,019	0	12,106	0	55.00
57.00	05700	CT SCAN	0	25,321	0	0	0	57.00
58.00	05800	MRI	0	13,811	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	18,415	0	33,268	0	59.00
59.97	05901	CARDIAC REHAB	0	9,207	0	31,143	0	59.97
60.00	06000	LABORATORY	0	131,207	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	25,321	0	8,185	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66,754	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	20,717	0	8,573	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,604	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	27,622	0	28,376	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,305,241	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	990,288	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	395,921	0	0	0	90.00
91.00	09100	EMERGENCY	0	128,905	0	318,687	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,015,518	1,680,365	0	1,799,544	2,295,529	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS	0	0	0	0	0	190.01
191.01	19101	PATIENT TRANSPORTATION	0	11,509	0	0	0	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	2,302	0	0	0	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	0	0	0	0	0	194.00
194.01	07951	MH HOSPITALIST	0	9,207	0	0	0	194.01
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)	2,015,518	1,703,383	0	1,799,544	2,295,529	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	
			15.00	16.00	17.00	19.00	21.00	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	18,678,295					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,893,216				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		0		19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0		22.00
23.00	02300	PARAMED ED PRGM	0	0		0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	106,074	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	17,422	0	0	0	31.00
43.00	04300	NURSERY	0	7,702	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	176,853	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	22,412	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,057	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	43,648	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	121,843	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE	0	37,416	0	0	0	54.01
54.02	05402	ULTRASOUND	0	97,464	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	31,319	0	0	0	55.00
57.00	05700	CT SCAN	0	427,150	0	0	0	57.00
58.00	05800	MRI	0	73,340	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59,523	0	0	0	59.00
59.97	05901	CARDIAC REHAB	0	7,449	0	0	0	59.97
60.00	06000	LABORATORY	0	567,713	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	38,041	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	49,420	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,857	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,049	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	109,450	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	76,492	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	65,224	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,678,295	234,120	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	129,303	0	0	0	90.00
91.00	09100	EMERGENCY	0	372,875	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,678,295	2,893,216	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS	0	0	0	0	0	190.01
191.01	19101	PATIENT TRANSPORTATION	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	0	0	0	0	0	194.00
194.01	07951	MH HOSPITALIST	0	0	0	0	0	194.01
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)	18,678,295	2,893,216	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0101

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Cost Center Description			INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			22.00	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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0					22.00
23.00	02300	PARAMED PRGM		0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	23,866,219	0	23,866,219	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	4,798,597	0	4,798,597	31.00
43.00	04300	NURSERY	0	0	2,195,173	0	2,195,173	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	9,809,128	0	9,809,128	50.00
51.00	05100	RECOVERY ROOM	0	0	891,549	0	891,549	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,304,616	0	1,304,616	52.00
53.00	05300	ANESTHESIOLOGY	0	0	66,791	0	66,791	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	6,028,761	0	6,028,761	54.00
54.01	05401	NUCLEAR MEDICINE	0	0	1,149,141	0	1,149,141	54.01
54.02	05402	ULTRASOUND	0	0	1,823,232	0	1,823,232	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	2,863,630	0	2,863,630	55.00
57.00	05700	CT SCAN	0	0	2,481,627	0	2,481,627	57.00
58.00	05800	MRI	0	0	2,287,936	0	2,287,936	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	2,395,950	0	2,395,950	59.00
59.97	05901	CARDIAC REHAB	0	0	584,111	0	584,111	59.97
60.00	06000	LABORATORY	0	0	14,522,566	0	14,522,566	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	2,932,337	0	2,932,337	65.00
66.00	06600	PHYSICAL THERAPY	0	0	5,171,152	0	5,171,152	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,298,557	0	1,298,557	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	279,408	0	279,408	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	2,335,631	0	2,335,631	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	10,168,695	0	10,168,695	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	7,722,197	0	7,722,197	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	18,912,415	0	18,912,415	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	30,300,808	0	30,300,808	90.00
91.00	09100	EMERGENCY	0	0	9,028,904	0	9,028,904	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	165,219,131	0	165,219,131	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS	0	0	0	0	0	190.01
191.01	19101	PATIENT TRANSPORTATION	0	0	549,905	0	549,905	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	32,551,756	0	32,551,756	192.00
193.00	19300	NONPAID WORKERS	0	0	2,302	0	2,302	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	0	0	20,685	0	20,685	194.00
194.01	07951	MH HOSPITALIST	0	0	4,844,398	0	4,844,398	194.01
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	203,188,177	0	203,188,177	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			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	49,488	39,054	88,542	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	949,853	1,339,069	1,056,731	3,345,653	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	42,532	842,664	664,992	1,550,188	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	3,321	201,891	159,323	364,535	9.00
10.00	01000	DIETARY	4,619	117,301	92,569	214,489	10.00
11.00	01100	CAFETERIA	0	60,200	47,507	107,707	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	78,122	14,387	11,354	103,863	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-22,527	65,660	51,816	94,949	14.00
15.00	01500	PHARMACY	216,371	79,391	62,652	358,414	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,465	2,735	6,200	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMEDICAL PRGM	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	744	536,100	423,065	959,909	30.00
31.00	03100	INTENSIVE CARE UNIT	194	181,255	143,038	324,487	31.00
43.00	04300	NURSERY	0	75,191	59,337	134,528	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	218,592	325,336	256,740	800,668	50.00
51.00	05100	RECOVERY ROOM	0	23,996	18,936	42,932	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	49,357	38,950	88,307	52.00
53.00	05300	ANESTHESIOLOGY	0	2,940	2,320	5,260	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,108	234,262	184,868	420,238	54.00
54.01	05401	NUCLEAR MEDICINE	188	27,356	21,588	49,132	54.01
54.02	05402	ULTRASOUND	275	8,322	6,568	15,165	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	326,939	87,241	68,847	483,027	55.00
57.00	05700	CT SCAN	2,330	81,649	64,434	148,413	57.00
58.00	05800	MRI	82	83,907	66,215	150,204	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,687	55,133	43,508	100,328	59.00
59.97	05901	CARDIAC REHAB	0	0	0	0	59.97
60.00	06000	LABORATORY	75,021	250,906	198,004	523,931	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	100,629	120,951	95,449	317,029	65.00
66.00	06600	PHYSICAL THERAPY	1,025	253,479	200,034	454,538	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	102,206	80,656	182,862	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	531,227	1,034,106	816,069	2,381,402	90.00
91.00	09100	EMERGENCY	2,568	165,739	130,794	299,101	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,534,900	6,472,948	5,108,153	14,116,001	118.00
NONREIMBURSABLE COST CENTERS							
190.01	19001	MEALS ON WHEELS	0	0	0	0	190.01
191.01	19101	PATIENT TRANSPORTATION	78	0	0	78	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	222,642	558,731	440,924	1,222,297	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	0	0	0	0	194.00
194.01	07951	MH HOSPITALIST	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,757,620	7,031,679	5,549,077	15,338,376	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,359,973					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	133,898	0	1,685,447			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,552	0	0	9,552		8.00
9.00	00900	HOUSEKEEPING	89,389	0	70,884	0	526,805	9.00
10.00	01000	DIETARY	27,633	0	41,185	0	13,438	10.00
11.00	01100	CAFETERIA	25,244	0	21,136	0	6,896	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	28,564	0	5,051	0	1,648	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	33,855	0	23,053	0	7,522	14.00
15.00	01500	PHARMACY	304,212	0	27,874	0	9,095	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	46,609	0	1,217	0	397	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	315,370	0	188,225	7,829	61,415	30.00
31.00	03100	INTENSIVE CARE UNIT	61,754	0	63,639	955	20,764	31.00
43.00	04300	NURSERY	27,255	0	26,399	768	8,614	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	138,106	0	114,226	0	37,270	50.00
51.00	05100	RECOVERY ROOM	12,414	0	8,425	0	2,749	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,894	0	17,329	0	5,654	52.00
53.00	05300	ANESTHESIOLOGY	240	0	1,032	0	337	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	84,304	0	82,250	0	26,837	54.00
54.01	05401	NUCLEAR MEDICINE	16,941	0	9,605	0	3,134	54.01
54.02	05402	ULTRASOUND	27,753	0	2,922	0	953	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	42,019	0	30,630	0	9,994	55.00
57.00	05700	CT SCAN	29,590	0	28,667	0	9,354	57.00
58.00	05800	MRI	32,318	0	29,460	0	9,612	58.00
59.00	05900	CARDIAC CATHETERIZATION	35,104	0	19,357	0	6,316	59.00
59.97	05901	CARDIAC REHAB	8,869	0	0	0	0	59.97
60.00	06000	LABORATORY	216,407	0	88,094	0	28,743	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	41,434	0	42,466	0	13,856	65.00
66.00	06600	PHYSICAL THERAPY	71,282	0	88,997	0	29,038	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,793	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,477	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	30,924	0	35,885	0	11,709	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	145,302	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	110,241	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	442,161	0	363,077	0	118,466	90.00
91.00	09100	EMERGENCY	127,688	0	58,191	0	18,987	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,759,596	0	1,489,276	9,552	462,798	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS	0	0	0	0	0	190.01
191.01	19101	PATIENT TRANSPORTATION	8,903	0	0	0	0	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	511,177	0	196,171	0	64,007	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	342	0	0	0	0	194.00
194.01	07951	MH HOSPITALIST	79,955	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,359,973	0	1,685,447	9,552	526,805	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	297,238					10.00
11.00	01100	CAFETERIA	0	161,862				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	2,844	0	142,952		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,250	0	12	165,740	14.00
15.00	01500	PHARMACY	0	4,593	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,125	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	243,633	28,654	0	54,600	0	30.00
31.00	03100	INTENSIVE CARE UNIT	29,720	4,812	0	16,249	0	31.00
43.00	04300	NURSERY	23,885	1,969	0	7,101	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	8,312	0	18,884	0	50.00
51.00	05100	RECOVERY ROOM	0	875	0	3,078	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,312	0	4,662	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,437	0	3,386	0	54.00
54.01	05401	NUCLEAR MEDICINE	0	656	0	0	0	54.01
54.02	05402	ULTRASOUND	0	2,187	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,187	0	962	0	55.00
57.00	05700	CT SCAN	0	2,406	0	0	0	57.00
58.00	05800	MRI	0	1,312	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,750	0	2,643	0	59.00
59.97	05901	CARDIAC REHAB	0	875	0	2,474	0	59.97
60.00	06000	LABORATORY	0	12,468	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,406	0	650	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,343	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,969	0	681	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	437	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,625	0	2,254	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	94,240	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	71,500	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	37,621	0	0	0	90.00
91.00	09100	EMERGENCY	0	12,249	0	25,316	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	297,238	159,674	0	142,952	165,740	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS	0	0	0	0	0	190.01
191.01	19101	PATIENT TRANSPORTATION	0	1,094	0	0	0	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	219	0	0	0	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	0	0	0	0	0	194.00
194.01	07951	MH HOSPITALIST	0	875	0	0	0	194.01
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)	297,238	161,862	0	142,952	165,740	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	
			15.00	16.00	17.00	19.00	21.00	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	706,388					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	62,096				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0		22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	2,284	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0	375	0			31.00
43.00	04300	NURSERY	0	166	0			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,809	0			50.00
51.00	05100	RECOVERY ROOM	0	483	0			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	109	0			52.00
53.00	05300	ANESTHESIOLOGY	0	940	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,624	0			54.00
54.01	05401	NUCLEAR MEDICINE	0	806	0			54.01
54.02	05402	ULTRASOUND	0	2,099	0			54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	674	0			55.00
57.00	05700	CT SCAN	0	9,199	0			57.00
58.00	05800	MRI	0	1,580	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,282	0			59.00
59.97	05901	CARDIAC REHAB	0	160	0			59.97
60.00	06000	LABORATORY	0	12,015	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	819	0			65.00
66.00	06600	PHYSICAL THERAPY	0	1,064	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	255	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	87	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,357	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,647	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,405	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	706,388	5,042	0			73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	2,785	0			90.00
91.00	09100	EMERGENCY	0	8,030	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0			93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	706,388	62,096	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS	0	0	0			190.01
191.01	19101	PATIENT TRANSPORTATION	0	0	0			191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0			192.00
193.00	19300	NONPAID WORKERS	0	0	0			193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	0	0	0			194.00
194.01	07951	MH HOSPITALIST	0	0	0			194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	706,388	62,096	0	0	0	202.00

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Cost Center Description			INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			22.00	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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0					22.00
23.00	02300	PARAMED PRGM		0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS			1,871,138	0	1,871,138	30.00
31.00	03100	INTENSIVE CARE UNIT			524,542	0	524,542	31.00
43.00	04300	NURSERY			231,436	0	231,436	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM			1,124,423	0	1,124,423	50.00
51.00	05100	RECOVERY ROOM			71,362	0	71,362	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM			135,760	0	135,760	52.00
53.00	05300	ANESTHESIOLOGY			7,809	0	7,809	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			629,560	0	629,560	54.00
54.01	05401	NUCLEAR MEDICINE			80,596	0	80,596	54.01
54.02	05402	ULTRASOUND			51,996	0	51,996	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC			570,100	0	570,100	55.00
57.00	05700	CT SCAN			228,447	0	228,447	57.00
58.00	05800	MRI			224,944	0	224,944	58.00
59.00	05900	CARDIAC CATHETERIZATION			167,509	0	167,509	59.00
59.97	05901	CARDIAC REHAB			12,684	0	12,684	59.97
60.00	06000	LABORATORY			885,002	0	885,002	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS			0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY			419,552	0	419,552	65.00
66.00	06600	PHYSICAL THERAPY			653,348	0	653,348	66.00
67.00	06700	OCCUPATIONAL THERAPY			24,365	0	24,365	67.00
68.00	06800	SPEECH PATHOLOGY			5,156	0	5,156	68.00
69.00	06900	ELECTROCARDIOLOGY			269,471	0	269,471	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT			241,189	0	241,189	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS			183,146	0	183,146	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS			711,430	0	711,430	73.00
76.97	07697	CARDIAC REHABILITATION			0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY			0	0	0	76.98
76.99	07699	LITHOTRIPSY			0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC			3,357,997	0	3,357,997	90.00
91.00	09100	EMERGENCY			553,775	0	553,775	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM			0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	13,236,737	0	13,236,737	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS			0	0	0	190.01
191.01	19101	PATIENT TRANSPORTATION			10,328	0	10,328	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES			2,007,933	0	2,007,933	192.00
193.00	19300	NONPAID WORKERS			219	0	219	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM			351	0	351	194.00
194.01	07951	MH HOSPITALIST			82,808	0	82,808	194.01
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	15,338,376	0	15,338,376	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0101

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

Worksheet B-1

Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	267,836					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		267,836				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,885	1,885	96,077,823			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	51,005	51,005	15,577,729	-44,250,374	158,937,803	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	32,097	32,097	1,475,798	0	6,333,851	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	451,850	8.00
9.00	00900	HOUSEKEEPING	7,690	7,690	2,166,099	0	4,228,437	9.00
10.00	01000	DIETARY	4,468	4,468	535,227	0	1,307,153	10.00
11.00	01100	CAFETERIA	2,293	2,293	953,271	0	1,194,149	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	548	548	1,065,605	0	1,351,186	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,501	2,501	1,192,397	0	1,601,466	14.00
15.00	01500	PHARMACY	3,024	3,024	2,386,103	0	14,390,370	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	132	132	1,678,487	0	2,204,756	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,420	20,420	9,998,394	0	14,918,173	30.00
31.00	03100	INTENSIVE CARE UNIT	6,904	6,904	1,937,721	0	2,921,178	31.00
43.00	04300	NURSERY	2,864	2,864	814,072	0	1,289,257	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,392	12,392	3,414,370	0	6,532,931	50.00
51.00	05100	RECOVERY ROOM	914	914	440,054	0	587,228	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,880	1,880	534,492	0	846,462	52.00
53.00	05300	ANESTHESIOLOGY	112	112	0	0	11,349	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,923	8,923	2,694,354	0	3,987,882	54.00
54.01	05401	NUCLEAR MEDICINE	1,042	1,042	348,964	0	801,377	54.01
54.02	05402	ULTRASOUND	317	317	994,331	0	1,312,809	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	3,323	3,323	658,811	0	1,987,633	55.00
57.00	05700	CT SCAN	3,110	3,110	887,570	0	1,399,710	57.00
58.00	05800	MRI	3,196	3,196	497,198	0	1,528,775	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,100	2,100	790,159	0	1,660,540	59.00
59.97	05901	CARDIAC REHAB	0	0	331,510	0	419,514	59.97
60.00	06000	LABORATORY	9,557	9,557	3,627,032	0	10,236,832	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	4,607	4,607	966,936	0	1,959,960	65.00
66.00	06600	PHYSICAL THERAPY	9,655	9,655	2,262,394	0	3,371,896	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	723,667	0	983,571	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	168,539	0	211,790	68.00
69.00	06900	ELECTROCARDIOLOGY	3,893	3,893	927,042	0	1,462,808	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	6,873,336	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,214,813	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	39,389	39,389	13,541,564	0	20,915,851	90.00
91.00	09100	EMERGENCY	6,313	6,313	4,569,543	0	6,040,121	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	246,554	246,554	78,159,433	-44,250,374	130,539,014	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS	0	0	0	0	0	190.01
191.01	19101	PATIENT TRANSPORTATION	0	0	273,941	0	421,144	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	21,282	21,282	15,488,975	0	24,179,283	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	0	0	9,669	0	16,180	194.00
194.01	07951	MH HOSPITALIST	0	0	2,145,805	0	3,782,182	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0101

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

Worksheet B-1

Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	7,031,679	5,549,077	22,275,581		44,250,374	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.253674	20.718189	0.231849		0.278413	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			88,542		3,359,973	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000922		0.021140	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: 14-0101

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

Worksheet B-1

Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	
			6.00	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						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	182,849				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	14,162			8.00
9.00	00900	HOUSEKEEPING	0	7,690	0	175,159		9.00
10.00	01000	DIETARY	0	4,468	0	4,468	14,162	10.00
11.00	01100	CAFETERIA	0	2,293	0	2,293	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	548	0	548	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,501	0	2,501	0	14.00
15.00	01500	PHARMACY	0	3,024	0	3,024	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	132	0	132	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	20,420	11,608	20,420	11,608	30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,904	1,416	6,904	1,416	31.00
43.00	04300	NURSERY	0	2,864	1,138	2,864	1,138	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	12,392	0	12,392	0	50.00
51.00	05100	RECOVERY ROOM	0	914	0	914	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,880	0	1,880	0	52.00
53.00	05300	ANESTHESIOLOGY	0	112	0	112	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,923	0	8,923	0	54.00
54.01	05401	NUCLEAR MEDICINE	0	1,042	0	1,042	0	54.01
54.02	05402	ULTRASOUND	0	317	0	317	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	3,323	0	3,323	0	55.00
57.00	05700	CT SCAN	0	3,110	0	3,110	0	57.00
58.00	05800	MRI	0	3,196	0	3,196	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,100	0	2,100	0	59.00
59.97	05901	CARDIAC REHAB	0	0	0	0	0	59.97
60.00	06000	LABORATORY	0	9,557	0	9,557	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	4,607	0	4,607	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,655	0	9,655	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	3,893	0	3,893	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	39,389	0	39,389	0	90.00
91.00	09100	EMERGENCY	0	6,313	0	6,313	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	161,567	14,162	153,877	14,162	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS	0	0	0	0	0	190.01
191.01	19101	PATIENT TRANSPORTATION	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	21,282	0	21,282	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	0	0	0	0	0	194.00
194.01	07951	MH HOSPITALIST	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	8,097,277	577,651	5,746,233	2,015,518	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	44.283956	40.788801	32.805811	142.318740	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0101

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	0	1,685,447	9,552	526,805	297,238	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	9.217699	0.674481	3.007582	20.988420	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: 14-0101

Period:
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To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description			CAFETERIA (FTEs)	MAINTENANCE OF PERSONNEL (SQUARE FEET)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	740					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	13	0	375,938			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	24	0	31	12,088,149		14.00
15.00	01500	PHARMACY	21	0	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	131	0	143,588	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	22	0	42,733	0	0	31.00
43.00	04300	NURSERY	9	0	18,674	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	38	0	49,662	0	0	50.00
51.00	05100	RECOVERY ROOM	4	0	8,095	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6	0	12,261	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34	0	8,904	0	0	54.00
54.01	05401	NUCLEAR MEDICINE	3	0	0	0	0	54.01
54.02	05402	ULTRASOUND	10	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	10	0	2,529	0	0	55.00
57.00	05700	CT SCAN	11	0	0	0	0	57.00
58.00	05800	MRI	6	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	8	0	6,950	0	0	59.00
59.97	05901	CARDIAC REHAB	4	0	6,506	0	0	59.97
60.00	06000	LABORATORY	57	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	11	0	1,710	0	0	65.00
66.00	06600	PHYSICAL THERAPY	29	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	9	0	1,791	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12	0	5,928	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,873,336	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,214,813	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	172	0	0	0	0	90.00
91.00	09100	EMERGENCY	56	0	66,576	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	730	0	375,938	12,088,149	100	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS	0	0	0	0	0	190.01
191.01	19101	PATIENT TRANSPORTATION	5	0	0	0	0	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	1	0	0	0	0	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	0	0	0	0	0	194.00
194.01	07951	MH HOSPITALIST	4	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,703,383	0	1,799,544	2,295,529	18,678,295	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2,301.868919	0.000000	4.786811	0.189899	186,782.950000	203.00

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 14-0101		Period: From 01/01/2023 To 12/31/2023	Worksheet B-1 Date/Time Prepared: 5/31/2024 12:19 pm	
Cost Center Description			CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (SQUARE FEET)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)
			11.00	12.00	13.00	14.00	15.00
204.00		Cost to be allocated (per Wkst. B, Part II)	161,862	0	142,952	165,740	706,388
205.00		Unit cost multiplier (Wkst. B, Part II)	218.732432	0.000000	0.380254	0.013711	7,063.880000
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0101

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

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Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS		
							SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
			16.00		17.00	19.00	21.00	22.00	
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
6.00	00600	MAINTENANCE & REPAIRS							6.00
7.00	00700	OPERATION OF PLANT							7.00
8.00	00800	LAUNDRY & LINEN SERVICE							8.00
9.00	00900	HOUSEKEEPING							9.00
10.00	01000	DIETARY							10.00
11.00	01100	CAFETERIA							11.00
12.00	01200	MAINTENANCE OF PERSONNEL							12.00
13.00	01300	NURSING ADMINISTRATION							13.00
14.00	01400	CENTRAL SERVICES & SUPPLY							14.00
15.00	01500	PHARMACY							15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	842,029,206						16.00
17.00	01700	SOCIAL SERVICE	0	0					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		0			19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				0	22.00
23.00	02300	PARAMED ED PRGM	0	0					23.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	30,871,228		0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,070,455		0	0	0	0	31.00
43.00	04300	NURSERY	2,241,660		0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	51,470,689		0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	6,522,816		0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,471,797		0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	12,703,172		0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,460,631		0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE	10,889,348		0	0	0	0	54.01
54.02	05402	ULTRASOUND	28,365,491		0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	9,114,824		0	0	0	0	55.00
57.00	05700	CT SCAN	124,316,014		0	0	0	0	57.00
58.00	05800	MRI	21,344,608		0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	17,323,274		0	0	0	0	59.00
59.97	05901	CARDIAC REHAB	2,167,826		0	0	0	0	59.97
60.00	06000	LABORATORY	165,224,284		0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	11,071,195		0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	14,382,997		0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,450,806		0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,178,274		0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	31,853,797		0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,261,882		0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,982,670		0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,137,476		0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	37,631,782		0	0	0	0	90.00
91.00	09100	EMERGENCY	108,520,210		0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART							92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	842,029,206		0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS									
190.01	19001	MEALS ON WHEELS	0	0	0	0	0	0	190.01
191.01	19101	PATIENT TRANSPORTATION	0	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	0	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	0	0	0	0	0	0	194.00
194.01	07951	MH HOSPITALIST	0	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments							200.00
201.00		Negative Cost Centers							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0101

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS		
						SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
						16.00	17.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	2,893,216	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.003436	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	62,096	0	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000074	0.000000	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0101

Period:
From 01/01/2023
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Worksheet B-1

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Cost Center Description		PARAMED PRGM (ASSIGNED TIME)	
		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
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED PRGM	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	NUCLEAR MEDICINE	54.01
54.02	05402	ULTRASOUND	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
59.97	05901	CARDIAC REHAB	59.97
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.01	19001	MEALS ON WHEELS	190.01
191.01	19101	PATIENT TRANSPORTATION	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	194.00
194.01	07951	MH HOSPITALIST	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00

Cost Center Description		PARAMED ED PRGM (ASSIGNED TIME)		
		23.00		
204.00	Cost to be allocated (per Wkst. B, Part II)	0		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	0		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0101

Period:
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				Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		Total Costs	
						RCE			
						Disallowance			
			1.00	2.00	3.00	4.00		5.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	23,866,219		23,866,219	0		23,866,219	30.00
31.00	03100	INTENSIVE CARE UNIT	4,798,597		4,798,597	0		4,798,597	31.00
43.00	04300	NURSERY	2,195,173		2,195,173	0		2,195,173	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	9,809,128		9,809,128	0		9,809,128	50.00
51.00	05100	RECOVERY ROOM	891,549		891,549	0		891,549	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,304,616		1,304,616	0		1,304,616	52.00
53.00	05300	ANESTHESIOLOGY	66,791		66,791	0		66,791	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,028,761		6,028,761	0		6,028,761	54.00
54.01	05401	NUCLEAR MEDICINE	1,149,141		1,149,141	0		1,149,141	54.01
54.02	05402	ULTRASOUND	1,823,232		1,823,232	0		1,823,232	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	2,863,630		2,863,630	0		2,863,630	55.00
57.00	05700	CT SCAN	2,481,627		2,481,627	0		2,481,627	57.00
58.00	05800	MRI	2,287,936		2,287,936	0		2,287,936	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,395,950		2,395,950	0		2,395,950	59.00
59.97	05901	CARDIAC REHAB	584,111		584,111	0		584,111	59.97
60.00	06000	LABORATORY	14,522,566		14,522,566	0		14,522,566	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0		0	62.30
65.00	06500	RESPIRATORY THERAPY	2,932,337	0	2,932,337	0		2,932,337	65.00
66.00	06600	PHYSICAL THERAPY	5,171,152	0	5,171,152	0		5,171,152	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,298,557	0	1,298,557	0		1,298,557	67.00
68.00	06800	SPEECH PATHOLOGY	279,408	0	279,408	0		279,408	68.00
69.00	06900	ELECTROCARDIOLOGY	2,335,631		2,335,631	0		2,335,631	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,168,695		10,168,695	0		10,168,695	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,722,197		7,722,197	0		7,722,197	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,912,415		18,912,415	0		18,912,415	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0		0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0		0	76.98
76.99	07699	LITHOTRIPSY	0		0	0		0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	30,300,808		30,300,808	0		30,300,808	90.00
91.00	09100	EMERGENCY	9,028,904		9,028,904	0		9,028,904	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,684,157		3,684,157	0		3,684,157	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0		0	93.99
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	168,903,288	0	168,903,288	0		168,903,288	200.00
201.00		Less Observation Beds	3,684,157		3,684,157			3,684,157	201.00
202.00		Total (see instructions)	165,219,131	0	165,219,131	0		165,219,131	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0101

Period:
From 01/01/2023
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Part I
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			Title XVIII			Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,335,397		26,335,397			30.00	
31.00	03100	INTENSIVE CARE UNIT	5,070,455		5,070,455			31.00	
43.00	04300	NURSERY	2,241,660		2,241,660			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,054,089	42,416,600	51,470,689	0.190577	0.000000	50.00	
51.00	05100	RECOVERY ROOM	1,726,535	4,796,281	6,522,816	0.136682	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,471,797	0	1,471,797	0.886410	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	2,805,589	9,897,583	12,703,172	0.005258	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,766,534	28,694,097	35,460,631	0.170013	0.000000	54.00	
54.01	05401	NUCLEAR MEDICINE	1,038,443	9,850,905	10,889,348	0.105529	0.000000	54.01	
54.02	05402	ULTRASOUND	3,074,565	25,290,926	28,365,491	0.064276	0.000000	54.02	
55.00	05500	RADIOLOGY-THERAPEUTIC	1,938	9,112,886	9,114,824	0.314173	0.000000	55.00	
57.00	05700	CT SCAN	20,055,619	104,260,395	124,316,014	0.019962	0.000000	57.00	
58.00	05800	MRI	2,573,650	18,770,958	21,344,608	0.107190	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	6,316,064	11,007,210	17,323,274	0.138308	0.000000	59.00	
59.97	05901	CARDIAC REHAB	0	2,167,826	2,167,826	0.269446	0.000000	59.97	
60.00	06000	LABORATORY	34,203,246	131,021,038	165,224,284	0.087896	0.000000	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30	
65.00	06500	RESPIRATORY THERAPY	8,391,848	2,679,347	11,071,195	0.264862	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	3,110,612	11,272,385	14,382,997	0.359532	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	1,603,269	1,847,537	3,450,806	0.376305	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	603,131	575,143	1,178,274	0.237133	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	6,758,199	25,095,598	31,853,797	0.073323	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,887,790	15,374,092	22,261,882	0.456776	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,837,089	14,145,581	18,982,670	0.406802	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	17,759,208	50,378,268	68,137,476	0.277563	0.000000	73.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	66,102	37,565,680	37,631,782	0.805192	0.000000	90.00	
91.00	09100	EMERGENCY	18,912,526	89,607,684	108,520,210	0.083200	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	598,329	3,937,502	4,535,831	0.812234	0.000000	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	192,263,684	649,765,522	842,029,206			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	192,263,684	649,765,522	842,029,206			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.190577			50.00
51.00	05100 RECOVERY ROOM	0.136682			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.886410			52.00
53.00	05300 ANESTHESIOLOGY	0.005258			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.170013			54.00
54.01	05401 NUCLEAR MEDICINE	0.105529			54.01
54.02	05402 ULTRASOUND	0.064276			54.02
55.00	05500 RADIOLOGY-THERAPEUTIC	0.314173			55.00
57.00	05700 CT SCAN	0.019962			57.00
58.00	05800 MRI	0.107190			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.138308			59.00
59.97	05901 CARDIAC REHAB	0.269446			59.97
60.00	06000 LABORATORY	0.087896			60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500 RESPIRATORY THERAPY	0.264862			65.00
66.00	06600 PHYSICAL THERAPY	0.359532			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.376305			67.00
68.00	06800 SPEECH PATHOLOGY	0.237133			68.00
69.00	06900 ELECTROCARDIOLOGY	0.073323			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.456776			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.406802			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.277563			73.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699 LI THOTRI PSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.805192			90.00
91.00	09100 EMERGENCY	0.083200			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.812234			92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/31/2024 12:19 pm

			Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		
						RCE	Total Costs	
						Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	23,866,219		23,866,219	0	23,866,219	30.00
31.00	03100	INTENSIVE CARE UNIT	4,798,597		4,798,597	0	4,798,597	31.00
43.00	04300	NURSERY	2,195,173		2,195,173	0	2,195,173	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,809,128		9,809,128	0	9,809,128	50.00
51.00	05100	RECOVERY ROOM	891,549		891,549	0	891,549	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,304,616		1,304,616	0	1,304,616	52.00
53.00	05300	ANESTHESIOLOGY	66,791		66,791	0	66,791	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,028,761		6,028,761	0	6,028,761	54.00
54.01	05401	NUCLEAR MEDICINE	1,149,141		1,149,141	0	1,149,141	54.01
54.02	05402	ULTRASOUND	1,823,232		1,823,232	0	1,823,232	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	2,863,630		2,863,630	0	2,863,630	55.00
57.00	05700	CT SCAN	2,481,627		2,481,627	0	2,481,627	57.00
58.00	05800	MRI	2,287,936		2,287,936	0	2,287,936	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,395,950		2,395,950	0	2,395,950	59.00
59.97	05901	CARDIAC REHAB	584,111		584,111	0	584,111	59.97
60.00	06000	LABORATORY	14,522,566		14,522,566	0	14,522,566	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,932,337	0	2,932,337	0	2,932,337	65.00
66.00	06600	PHYSICAL THERAPY	5,171,152	0	5,171,152	0	5,171,152	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,298,557	0	1,298,557	0	1,298,557	67.00
68.00	06800	SPEECH PATHOLOGY	279,408	0	279,408	0	279,408	68.00
69.00	06900	ELECTROCARDIOLOGY	2,335,631		2,335,631	0	2,335,631	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,168,695		10,168,695	0	10,168,695	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,722,197		7,722,197	0	7,722,197	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,912,415		18,912,415	0	18,912,415	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	30,300,808		30,300,808	0	30,300,808	90.00
91.00	09100	EMERGENCY	9,028,904		9,028,904	0	9,028,904	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,684,157		3,684,157	0	3,684,157	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	168,903,288	0	168,903,288	0	168,903,288	200.00
201.00		Less Observation Beds	3,684,157		3,684,157		3,684,157	201.00
202.00		Total (see instructions)	165,219,131	0	165,219,131	0	165,219,131	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/31/2024 12:19 pm

			Title XIX			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00	
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00	
43.00	04300	NURSERY	0		0			43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00	
54.01	05401	NUCLEAR MEDICINE	0	0	0	0.000000	0.000000	54.01	
54.02	05402	ULTRASOUND	0	0	0	0.000000	0.000000	54.02	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00	
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00	
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00	
59.97	05901	CARDIAC REHAB	0	0	0	0.000000	0.000000	59.97	
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00	
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	0	0	0			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	0	0	0			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401	NUCLEAR MEDICINE	0.000000			54.01
54.02	05402	ULTRASOUND	0.000000			54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
59.97	05901	CARDIAC REHAB	0.000000			59.97
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

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

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part II
Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description			Title XIX			Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,809,128	1,124,423	8,684,705	0	0	50.00
51.00	05100	RECOVERY ROOM	891,549	71,362	820,187	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,304,616	135,760	1,168,856	0	0	52.00
53.00	05300	ANESTHESIOLOGY	66,791	7,809	58,982	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,028,761	629,560	5,399,201	0	0	54.00
54.01	05401	NUCLEAR MEDICINE	1,149,141	80,596	1,068,545	0	0	54.01
54.02	05402	ULTRASOUND	1,823,232	51,996	1,771,236	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	2,863,630	570,100	2,293,530	0	0	55.00
57.00	05700	CT SCAN	2,481,627	228,447	2,253,180	0	0	57.00
58.00	05800	MRI	2,287,936	224,944	2,062,992	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,395,950	167,509	2,228,441	0	0	59.00
59.97	05901	CARDIAC REHAB	584,111	12,684	571,427	0	0	59.97
60.00	06000	LABORATORY	14,522,566	885,002	13,637,564	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,932,337	419,552	2,512,785	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,171,152	653,348	4,517,804	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,298,557	24,365	1,274,192	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	279,408	5,156	274,252	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,335,631	269,471	2,066,160	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,168,695	241,189	9,927,506	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,722,197	183,146	7,539,051	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,912,415	711,430	18,200,985	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	30,300,808	3,357,997	26,942,811	0	0	90.00
91.00	09100	EMERGENCY	9,028,904	553,775	8,475,129	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,684,157	288,842	3,395,315	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	138,043,299	10,898,463	127,144,836	0	0	200.00
201.00		Less Observation Beds	3,684,157	288,842	3,395,315	0	0	201.00
202.00		Total (line 200 minus line 201)	134,359,142	10,609,621	123,749,521	0	0	202.00

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

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part II
Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description			Title XIX		Hospital	PPS
			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,809,128	51,470,689	0.190577	50.00
51.00	05100	RECOVERY ROOM	891,549	6,522,816	0.136682	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,304,616	1,471,797	0.886410	52.00
53.00	05300	ANESTHESIOLOGY	66,791	12,703,172	0.005258	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,028,761	35,460,631	0.170013	54.00
54.01	05401	NUCLEAR MEDICINE	1,149,141	10,889,348	0.105529	54.01
54.02	05402	ULTRASOUND	1,823,232	28,365,491	0.064276	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	2,863,630	9,114,824	0.314173	55.00
57.00	05700	CT SCAN	2,481,627	124,316,014	0.019962	57.00
58.00	05800	MRI	2,287,936	21,344,608	0.107190	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,395,950	17,323,274	0.138308	59.00
59.97	05901	CARDIAC REHAB	584,111	2,167,826	0.269446	59.97
60.00	06000	LABORATORY	14,522,566	165,224,284	0.087896	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	2,932,337	11,071,195	0.264862	65.00
66.00	06600	PHYSICAL THERAPY	5,171,152	14,382,997	0.359532	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,298,557	3,450,806	0.376305	67.00
68.00	06800	SPEECH PATHOLOGY	279,408	1,178,274	0.237133	68.00
69.00	06900	ELECTROCARDIOLOGY	2,335,631	31,853,797	0.073323	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,168,695	22,261,882	0.456776	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,722,197	18,982,670	0.406802	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,912,415	68,137,476	0.277563	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	30,300,808	37,631,782	0.805192	90.00
91.00	09100	EMERGENCY	9,028,904	108,520,210	0.083200	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,684,157	4,535,831	0.812234	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	93.99
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (sum of lines 50 thru 199)	138,043,299	808,381,694		200.00
201.00		Less Observation Beds	3,684,157	0		201.00
202.00		Total (line 200 minus line 201)	134,359,142	808,381,694		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/31/2024 12:19 pm

			Title V		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	23,866,219		23,866,219	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,798,597		4,798,597	0	0	31.00
43.00	04300	NURSERY	2,195,173		2,195,173	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,809,128		9,809,128	0	0	50.00
51.00	05100	RECOVERY ROOM	891,549		891,549	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,304,616		1,304,616	0	0	52.00
53.00	05300	ANESTHESIOLOGY	66,791		66,791	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,028,761		6,028,761	0	0	54.00
54.01	05401	NUCLEAR MEDICINE	1,149,141		1,149,141	0	0	54.01
54.02	05402	ULTRASOUND	1,823,232		1,823,232	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	2,863,630		2,863,630	0	0	55.00
57.00	05700	CT SCAN	2,481,627		2,481,627	0	0	57.00
58.00	05800	MRI	2,287,936		2,287,936	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,395,950		2,395,950	0	0	59.00
59.97	05901	CARDIAC REHAB	584,111		584,111	0	0	59.97
60.00	06000	LABORATORY	14,522,566		14,522,566	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,932,337	0	2,932,337	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,171,152	0	5,171,152	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,298,557	0	1,298,557	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	279,408	0	279,408	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,335,631		2,335,631	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,168,695		10,168,695	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,722,197		7,722,197	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,912,415		18,912,415	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	30,300,808		30,300,808	0	0	90.00
91.00	09100	EMERGENCY	9,028,904		9,028,904	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	165,219,131	0	165,219,131	0	0	200.00
201.00		Less Observation Beds	0		0			201.00
202.00		Total (see instructions)	165,219,131	0	165,219,131	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/31/2024 12:19 pm

			Title V			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	0		0			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE	0	0	0	0.000000	0.000000	54.01
54.02	05402	ULTRASOUND	0	0	0	0.000000	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
59.97	05901	CARDIAC REHAB	0	0	0	0.000000	0.000000	59.97
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	0	0	0			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	0	0	0			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description			PPS Inpatient Ratio	Title V	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401	NUCLEAR MEDICINE	0.000000			54.01
54.02	05402	ULTRASOUND	0.000000			54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
59.97	05901	CARDIAC REHAB	0.000000			59.97
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part I
Date/Time Prepared:
5/31/2024 12:19 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	1,871,138	0	1,871,138	13,727	136.31	30.00
31.00	INTENSIVE CARE UNIT	524,542		524,542	1,416	370.44	31.00
43.00	NURSERY	231,436		231,436	1,138	203.37	43.00
200.00	Total (lines 30 through 199)	2,627,116		2,627,116	16,281		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	5,550	756,521				30.00
31.00	INTENSIVE CARE UNIT	647	239,675				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	6,197	996,196				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part II
Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description			Title XVIII		Hospital	PPS		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1, 124, 423	51, 470, 689	0. 021846	5, 064, 513	110, 639	50.00
51.00	05100	RECOVERY ROOM	71, 362	6, 522, 816	0. 010940	743, 435	8, 133	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	135, 760	1, 471, 797	0. 092241	0	0	52.00
53.00	05300	ANESTHESIOLOGY	7, 809	12, 703, 172	0. 000615	1, 331, 477	819	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	629, 560	35, 460, 631	0. 017754	3, 581, 516	63, 586	54.00
54.01	05401	NUCLEAR MEDICINE	80, 596	10, 889, 348	0. 007401	570, 761	4, 224	54.01
54.02	05402	ULTRASOUND	51, 996	28, 365, 491	0. 001833	1, 588, 329	2, 911	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	570, 100	9, 114, 824	0. 062546	1, 011	63	55.00
57.00	05700	CT SCAN	228, 447	124, 316, 014	0. 001838	10, 416, 284	19, 145	57.00
58.00	05800	MRI	224, 944	21, 344, 608	0. 010539	1, 208, 534	12, 737	58.00
59.00	05900	CARDIAC CATHETERIZATION	167, 509	17, 323, 274	0. 009670	2, 814, 156	27, 213	59.00
59.97	05901	CARDIAC REHAB	12, 684	2, 167, 826	0. 005851	0	0	59.97
60.00	06000	LABORATORY	885, 002	165, 224, 284	0. 005356	16, 037, 230	85, 895	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	419, 552	11, 071, 195	0. 037896	4, 541, 109	172, 090	65.00
66.00	06600	PHYSICAL THERAPY	653, 348	14, 382, 997	0. 045425	1, 836, 574	83, 426	66.00
67.00	06700	OCCUPATIONAL THERAPY	24, 365	3, 450, 806	0. 007061	969, 083	6, 843	67.00
68.00	06800	SPEECH PATHOLOGY	5, 156	1, 178, 274	0. 004376	334, 628	1, 464	68.00
69.00	06900	ELECTROCARDIOLOGY	269, 471	31, 853, 797	0. 008460	3, 485, 151	29, 484	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	241, 189	22, 261, 882	0. 010834	3, 381, 756	36, 638	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	183, 146	18, 982, 670	0. 009648	3, 236, 641	31, 227	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	711, 430	68, 137, 476	0. 010441	8, 190, 893	85, 521	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0. 000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0. 000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0. 000000	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3, 357, 997	37, 631, 782	0. 089233	15, 762	1, 406	90.00
91.00	09100	EMERGENCY	553, 775	108, 520, 210	0. 005103	9, 589, 278	48, 934	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	288, 842	4, 535, 831	0. 063680	362, 113	23, 059	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0. 000000	0	0	93.99
200.00		Total (lines 50 through 199)	10, 898, 463	808, 381, 694		79, 300, 234	855, 457	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0101		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Prepared: 5/31/2024 12:19 pm	
				Title XVIII		Hospital	PPS	
Cost Center Description				Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost
				1A	1.00	2A	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0	0
200.00		Total (lines 30 through 199)	0	0	0	0	0	0
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	13,727	0.00	5,550	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	1,416	0.00	647	31.00
43.00	04300	NURSERY	0	0	1,138	0.00	0	43.00
200.00		Total (lines 30 through 199)	0	0	16,281		6,197	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
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: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part IV
Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description			Title XVIII			Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health		
			1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE	0	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
59.97	05901	CARDIAC REHAB	0	0	0	0	0	0	59.97
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part IV
Date/Time Prepared:
5/31/2024 12:19 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	51,470,689	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	6,522,816	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,471,797	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	12,703,172	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	35,460,631	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE	0	0	0	10,889,348	0.000000	54.01
54.02	05402	ULTRASOUND	0	0	0	28,365,491	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	9,114,824	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	124,316,014	0.000000	57.00
58.00	05800	MRI	0	0	0	21,344,608	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	17,323,274	0.000000	59.00
59.97	05901	CARDIAC REHAB	0	0	0	2,167,826	0.000000	59.97
60.00	06000	LABORATORY	0	0	0	165,224,284	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,071,195	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	14,382,997	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,450,806	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,178,274	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	31,853,797	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	22,261,882	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,982,670	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	68,137,476	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	37,631,782	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	108,520,210	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,535,831	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	808,381,694		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part IV
Date/Time Prepared:
5/31/2024 12:19 pm

				Title XVIII		Hospital		PPS		
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
				9.00	10.00	11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	5,064,513	0	10,060,516	0	50.00		
51.00	05100	RECOVERY ROOM	0.000000	743,435	0	1,078,175	0	51.00		
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00		
53.00	05300	ANESTHESIOLOGY	0.000000	1,331,477	0	2,227,336	0	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,581,516	0	5,400,581	0	54.00		
54.01	05401	NUCLEAR MEDICINE	0.000000	570,761	0	3,893,772	0	54.01		
54.02	05402	ULTRASOUND	0.000000	1,588,329	0	4,278,251	0	54.02		
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	1,011	0	298,303	0	55.00		
57.00	05700	CT SCAN	0.000000	10,416,284	0	24,978,559	0	57.00		
58.00	05800	MRI	0.000000	1,208,534	0	4,991,888	0	58.00		
59.00	05900	CARDIAC CATHETERIZATION	0.000000	2,814,156	0	4,386,343	0	59.00		
59.97	05901	CARDIAC REHAB	0.000000	0	0	1,038,044	0	59.97		
60.00	06000	LABORATORY	0.000000	16,037,230	0	13,031,439	0	60.00		
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30		
65.00	06500	RESPIRATORY THERAPY	0.000000	4,541,109	0	790,065	0	65.00		
66.00	06600	PHYSICAL THERAPY	0.000000	1,836,574	0	230,899	0	66.00		
67.00	06700	OCCUPATIONAL THERAPY	0.000000	969,083	0	68,914	0	67.00		
68.00	06800	SPEECH PATHOLOGY	0.000000	334,628	0	18,641	0	68.00		
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,485,151	0	7,121,066	0	69.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	3,381,756	0	4,132,401	0	71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,236,641	0	4,726,728	0	72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	8,190,893	0	19,662,751	0	73.00		
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97		
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98		
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99		
	OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	15,762	0	2,941,358	0	90.00		
91.00	09100	EMERGENCY	0.000000	9,589,278	0	17,358,602	0	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	362,113	0	1,041,391	0	92.00		
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99		
200.00		Total (lines 50 through 199)		79,300,234	0	133,756,023	0	200.00		

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part V
Date/Time Prepared:
5/31/2024 12:19 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.190577	10,060,516	0	0	1,917,303	50.00
51.00	05100	RECOVERY ROOM	0.136682	1,078,175	0	0	147,367	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.886410	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.005258	2,227,336	0	0	11,711	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170013	5,400,581	0	0	918,169	54.00
54.01	05401	NUCLEAR MEDICINE	0.105529	3,893,772	0	0	410,906	54.01
54.02	05402	ULTRASOUND	0.064276	4,278,251	0	0	274,989	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.314173	298,303	0	0	93,719	55.00
57.00	05700	CT SCAN	0.019962	24,978,559	0	0	498,622	57.00
58.00	05800	MRI	0.107190	4,991,888	0	0	535,080	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.138308	4,386,343	0	0	606,666	59.00
59.97	05901	CARDIAC REHAB	0.269446	1,038,044	0	0	279,697	59.97
60.00	06000	LABORATORY	0.087896	13,031,439	0	0	1,145,411	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.264862	790,065	0	0	209,258	65.00
66.00	06600	PHYSICAL THERAPY	0.359532	230,899	0	0	83,016	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.376305	68,914	0	0	25,933	67.00
68.00	06800	SPEECH PATHOLOGY	0.237133	18,641	0	0	4,420	68.00
69.00	06900	ELECTROCARDIOLOGY	0.073323	7,121,066	0	0	522,138	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.456776	4,132,401	0	0	1,887,582	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.406802	4,726,728	0	0	1,922,842	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.277563	19,662,751	0	56,098	5,457,652	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.805192	2,941,358	0	10	2,368,358	90.00
91.00	09100	EMERGENCY	0.083200	17,358,602	0	9	1,444,236	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.812234	1,041,391	0	0	845,853	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Subtotal (see instructions)		133,756,023	0	56,117	21,610,928	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		133,756,023	0	56,117	21,610,928	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part V
Date/Time Prepared:
5/31/2024 12:19 pm

			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	NUCLEAR MEDICINE	0	0		54.01
54.02	05402	ULTRASOUND	0	0		54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
59.97	05901	CARDIAC REHAB	0	0		59.97
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,571		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	8		90.00
91.00	09100	EMERGENCY	0	1		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	0	15,580		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	15,580		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part I
Date/Time Prepared:
5/31/2024 12:19 pm

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		1,871,138	0	1,871,138	13,727	136.31	30.00
31.00	INTENSIVE CARE UNIT		524,542		524,542	1,416	370.44	31.00
43.00	NURSERY		231,436		231,436	1,138	203.37	43.00
200.00	Total (lines 30 through 199)		2,627,116		2,627,116	16,281		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		490	66,792				
31.00	INTENSIVE CARE UNIT		60	22,226				
43.00	NURSERY		48	9,762				
200.00	Total (lines 30 through 199)		598	98,780				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part II
Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description			Title XIX		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,124,423	0	0.000000	0	0 50.00
51.00	05100	RECOVERY ROOM	71,362	0	0.000000	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	135,760	0	0.000000	0	0 52.00
53.00	05300	ANESTHESIOLOGY	7,809	0	0.000000	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	629,560	0	0.000000	0	0 54.00
54.01	05401	NUCLEAR MEDICINE	80,596	0	0.000000	0	0 54.01
54.02	05402	ULTRASOUND	51,996	0	0.000000	0	0 54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	570,100	0	0.000000	0	0 55.00
57.00	05700	CT SCAN	228,447	0	0.000000	0	0 57.00
58.00	05800	MRI	224,944	0	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	167,509	0	0.000000	0	0 59.00
59.97	05901	CARDIAC REHAB	12,684	0	0.000000	0	0 59.97
60.00	06000	LABORATORY	885,002	0	0.000000	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	419,552	0	0.000000	0	0 65.00
66.00	06600	PHYSICAL THERAPY	653,348	0	0.000000	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	24,365	0	0.000000	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	5,156	0	0.000000	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	269,471	0	0.000000	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	241,189	0	0.000000	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	183,146	0	0.000000	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	711,430	0	0.000000	0	0 73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,357,997	0	0.000000	0	0 90.00
91.00	09100	EMERGENCY	553,775	0	0.000000	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	288,842	0	0.000000	0	0 92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0 93.99
200.00		Total (lines 50 through 199)	10,898,463	0		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0101		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Prepared: 5/31/2024 12:19 pm	
				Title XIX		Hospital	PPS	
Cost Center Description				Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost
				1A	1.00	2A	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0	0
200.00		Total (lines 30 through 199)	0	0	0	0	0	0
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	13,727	0.00	490	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	1,416	0.00	60	31.00
43.00	04300	NURSERY	0	0	1,138	0.00	48	43.00
200.00		Total (lines 30 through 199)	0	0	16,281		598	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
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: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part IV
Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description			Title XIX		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
59.97	05901	CARDIAC REHAB	0	0	0	0	0	59.97
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part IV
Date/Time Prepared:
5/31/2024 12:19 pm

			Title XIX		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE	0	0	0	0	0.000000	54.01
54.02	05402	ULTRASOUND	0	0	0	0	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
59.97	05901	CARDIAC REHAB	0	0	0	0	0.000000	59.97
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part IV
Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description		Title XIX			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE	0.000000	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0.000000	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
59.97	05901	CARDIAC REHAB	0.000000	0	0	0	0	59.97
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part I
Date/Time Prepared:
5/31/2024 12:19 pm

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		1,871,138	0	1,871,138	13,727	136.31	30.00
31.00	INTENSIVE CARE UNIT		524,542		524,542	1,416	370.44	31.00
43.00	NURSERY		231,436		231,436	1,138	203.37	43.00
200.00	Total (lines 30 through 199)		2,627,116		2,627,116	16,281		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		0	0				
31.00	INTENSIVE CARE UNIT		0	0				
43.00	NURSERY		0	0				
200.00	Total (lines 30 through 199)		0	0				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part II
Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description		Title V		Hospital		Cost	
		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	1,124,423	0	0.000000	0	0	50.00
51.00	05100 RECOVERY ROOM	71,362	0	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	135,760	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	7,809	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	629,560	0	0.000000	0	0	54.00
54.01	05401 NUCLEAR MEDICINE	80,596	0	0.000000	0	0	54.01
54.02	05402 ULTRASOUND	51,996	0	0.000000	0	0	54.02
55.00	05500 RADIOLOGY-THERAPEUTIC	570,100	0	0.000000	0	0	55.00
57.00	05700 CT SCAN	228,447	0	0.000000	0	0	57.00
58.00	05800 MRI	224,944	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	167,509	0	0.000000	0	0	59.00
59.97	05901 CARDIAC REHAB	12,684	0	0.000000	0	0	59.97
60.00	06000 LABORATORY	885,002	0	0.000000	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	419,552	0	0.000000	0	0	65.00
66.00	06600 PHYSICAL THERAPY	653,348	0	0.000000	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	24,365	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	5,156	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	269,471	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	241,189	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	183,146	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	711,430	0	0.000000	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	3,357,997	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	553,775	0	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00	Total (lines 50 through 199)	10,609,621	0		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0101		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part III Date/Time Prepared: 5/31/2024 12:19 pm	
					Title V		Hospital		Cost	
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		
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	13,727	0.00	0	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	1,416	0.00	0	31.00		
43.00	04300	NURSERY		0	1,138	0.00	0	43.00		
200.00		Total (lines 30 through 199)		0	16,281		0	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	
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: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part IV
Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description			Title V		Hospital		Cost
			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
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
54.01	05401	NUCLEAR MEDICINE	0	0	0	0	0 54.01
54.02	05402	ULTRASOUND	0	0	0	0	0 54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
59.97	05901	CARDIAC REHAB	0	0	0	0	0 59.97
60.00	06000	LABORATORY	0	0	0	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0 92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0 93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part IV
Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description			Title V		Hospital		Cost	
			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	0	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE	0	0	0	0	0.000000	54.01
54.02	05402	ULTRASOUND	0	0	0	0	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
59.97	05901	CARDIAC REHAB	0	0	0	0	0.000000	59.97
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part IV
Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description		Title V			Hospital		Cost	
		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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE	0.000000	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0.000000	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
59.97	05901	CARDIAC REHAB	0.000000	0	0	0	0	59.97
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0101	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/31/2024 12:19 pm
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		13,727	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		13,727	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)		11,608	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		5,550	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)		23,866,219	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)		23,866,219	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)		23,866,219	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)		1,738.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		9,649,397	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)		9,649,397	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0101

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

Worksheet D-1

Date/Time Prepared:
5/31/2024 12:19 pm

		Title XVIII		Hospital		PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,798,597	1,416	3,388.84	647	2,192,579	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)					12,783,784	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)					24,625,760	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)					996,196	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					855,457	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,851,653	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					22,774,107	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,119	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,738.63	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,684.157	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0101

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

Worksheet D-1

Date/Time Prepared:
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Cost Center Description		Title XVIII		Hospital		PPS	
		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	1,871,138	23,866,219	0.078401	3,684,157	288,842	90.00
91.00	Nursing Program cost	0	23,866,219	0.000000	3,684,157	0	91.00
92.00	Allied health cost	0	23,866,219	0.000000	3,684,157	0	92.00
93.00	All other Medical Education	0	23,866,219	0.000000	3,684,157	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0101	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/31/2024 12:19 pm
		Title XIX	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		13,727	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		13,727	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)		11,608	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)		490	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)		1,138	15.00
16.00	Nursery days (title V or XIX only)		48	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)		23,866,219	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)		23,866,219	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)		23,866,219	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)		1,738.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		851,929	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)		851,929	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0101

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

Worksheet D-1

Date/Time Prepared:

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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)	PPS
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	2,195,173	1,138	1,928.97	48	92,591	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	4,798,597	1,416	3,388.84	60	203,330	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)					0	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					1,147,850	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)					98,780	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)					98,780	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,049,070	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,119	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,738.63	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,684,157	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0101

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

Worksheet D-1

Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description		Title XIX		Hospital	PPS	
		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	1,871,138	23,866,219	0.078401	3,684,157	288,842
91.00	Nursing Program cost	0	23,866,219	0.000000	3,684,157	0
92.00	Allied health cost	0	23,866,219	0.000000	3,684,157	0
93.00	All other Medical Education	0	23,866,219	0.000000	3,684,157	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0101	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/31/2024 12:19 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
		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	11,154,691		30.00
31.00	03100	INTENSIVE CARE UNIT	2,667,319		31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.190577 5,064,513	965,180	50.00
51.00	05100	RECOVERY ROOM	0.136682 743,435	101,614	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.886410 0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.005258 1,331,477	7,001	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170013 3,581,516	608,904	54.00
54.01	05401	NUCLEAR MEDICINE	0.105529 570,761	60,232	54.01
54.02	05402	ULTRASOUND	0.064276 1,588,329	102,091	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.314173 1,011	318	55.00
57.00	05700	CT SCAN	0.019962 10,416,284	207,930	57.00
58.00	05800	MRI	0.107190 1,208,534	129,543	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.138308 2,814,156	389,220	59.00
59.97	05901	CARDIAC REHAB	0.269446 0	0	59.97
60.00	06000	LABORATORY	0.087896 16,037,230	1,409,608	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000 0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.264862 4,541,109	1,202,767	65.00
66.00	06600	PHYSICAL THERAPY	0.359532 1,836,574	660,307	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.376305 969,083	364,671	67.00
68.00	06800	SPEECH PATHOLOGY	0.237133 334,628	79,351	68.00
69.00	06900	ELECTROCARDIOLOGY	0.073323 3,485,151	255,542	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.456776 3,381,756	1,544,705	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.406802 3,236,641	1,316,672	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.277563 8,190,893	2,273,489	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000 0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000 0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000 0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.805192 15,762	12,691	90.00
91.00	09100	EMERGENCY	0.083200 9,589,278	797,828	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.812234 362,113	294,120	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000 0	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)	79,300,234	12,783,784	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)	0	0	201.00
202.00		Net charges (line 200 minus line 201)	79,300,234		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0101	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/31/2024 12:19 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)		11,008,253	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,836,136	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)		342,907	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		109,786	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)		83.19	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
5.01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)		0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)		0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)		0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.47	30.00
31.00	Percentage of Medicaid patient days (see instructions)		15.60	31.00
32.00	Sum of lines 30 and 31		17.07	32.00
33.00	Allowable disproportionate share percentage (see instructions)		3.85	33.00
34.00	Disproportionate share adjustment (see instructions)		142,878	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0101	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/31/2024 12:19 pm
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Payment Adjustment				
35.00	Total uncompensated care amount (see instructions)	6,874,403,459	0	35.00
35.01	Factor 3 (see instructions)	0.000139096	0.000000000	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	956,202	956,967	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	715,187	240,549	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	955,736		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
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	16,395,696		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)	16,395,696		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,152,713		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0		52.00
53.00	Nursing and Allied Health Managed Care payment	0		53.00
54.00	Special add-on payments for new technologies	56,744		54.00
54.01	Islet isolation add-on payment	0		54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0		55.00
55.01	Cellular therapy acquisition cost (see instructions)	0		55.01
56.00	Cost of physicians' services in a teaching hospital (see instructions)	0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0		58.00
59.00	Total (sum of amounts on lines 49 through 58)	17,605,153		59.00
60.00	Primary payer payments	1,055		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	17,604,098		61.00
62.00	Deductibles billed to program beneficiaries	1,674,364		62.00
63.00	Coinurance billed to program beneficiaries	20,400		63.00
64.00	Allowable bad debts (see instructions)	132,318		64.00
65.00	Adjusted reimbursable bad debts (see instructions)	86,007		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	64,661		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	15,995,341		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)	0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)	0		70.50
70.75	N95 respirator payment adjustment amount (see instructions)	0		70.75
70.87	Demonstration payment adjustment amount before sequestration	0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0		70.91
70.92	Bundled Model 1 discount amount (see instructions)	0		70.92
70.93	HVBP payment adjustment amount (see instructions)	-18,471		70.93
70.94	HRR adjustment amount (see instructions)	-69,209		70.94
70.95	Recovery of accelerated depreciation	0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0101	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/31/2024 12:19 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2023	29,502	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)	2024	59,347	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		45,630	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		15,950,880	71.00
71.01	Sequestration adjustment (see instructions)		319,018	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		15,386,155	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)		245,707	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		532,620	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)		1,204,924	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		131,092	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	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	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	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
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/31/2024 12:19 pm

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	11,008,253	0	11,008,253		11,008,253	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,836,136	0		3,836,136	3,836,136	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	342,907	0	342,907		342,907	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	109,786	0		109,786	109,786	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	0.0385	0.0385	0.0385	0.0385		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	142,878	0	105,955	36,923	142,878	11.00
11.01	Uncompensated care payments	36.00	955,736	0	715,187	240,549	955,736	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	16,395,696	0	12,172,302	4,223,394	16,395,696	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	16,395,696	0	12,172,302	4,223,394	16,395,696	15.00
16.00	Payment for inpatient program capital (From Wkst. L, Pt. I, if applicable)	50.00	1,152,713	0	847,888	304,825	1,152,713	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/31/2024 12:19 pm

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	56,744	0	56,744	0	56,744	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	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	13,076,934	4,528,219	17,605,153	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	1,125,520	0	828,027	297,493	1,125,520	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	27,193	0	19,861	7,332	27,193	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	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,152,713	0	847,888	304,825	1,152,713	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				0.002256	0.013106		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			29,502		29,502	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				59,347	59,347	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: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/31/2024 12:19 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (col s. 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	11,008,253	11,008,253		11,008,253	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,836,136		3,836,136	3,836,136	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	342,907	342,907		342,907	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	109,786		109,786	109,786	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	0.0385	0.0385	0.0385		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	142,878	105,955	36,923	142,878	11.00
11.01	Uncompensated care payments	36.00	955,736	715,187	240,549	955,736	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	16,395,696	12,172,302	4,223,394	16,395,696	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	16,395,696	12,172,302	4,223,394	16,395,696	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,152,713	847,888	304,825	1,152,713	16.00
17.00	Special add-on payments for new technologies	54.00	56,744	56,744	0	56,744	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			13,076,934	4,528,219	17,605,153	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/31/2024 12:19 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	1,125,520	828,027	297,493	1,125,520	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	27,193	19,861	7,332	27,193	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,152,713	847,888	304,825	1,152,713	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	29,502	29,502		29,502	28.00
29.00	Low volume adjustment on or after October 1	70.97	59,347		59,347	59,347	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-18,471	0	-18,471	-18,471	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	-69,209	-63,071	-6,138	-69,209	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	45,630	45,630	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0101	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/31/2024 12:19 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		15,580	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		21,610,928	2.00
3.00	OPPS or REH payments		14,198,879	3.00
4.00	Outlier payment (see instructions)		41,692	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 including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		15,580	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		56,117	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)		56,117	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)		56,117	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		40,537	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)		15,580	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)		14,240,571	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)		2,718,756	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)		11,537,395	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
28.50	REH facility payment amount (see instructions)			28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)		11,537,395	30.00
31.00	Primary payer payments		2,465	31.00
32.00	Subtotal (line 30 minus line 31)		11,534,930	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)		140,941	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		91,612	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		76,847	36.00
37.00	Subtotal (see instructions)		11,626,542	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-134	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)		11,626,676	40.00
40.01	Sequestration adjustment (see instructions)		232,534	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		11,299,454	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)		94,688	43.00
43.01	Balance due provi der/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		238,192	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		144,030	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0101	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/31/2024 12:19 pm	
		Title XVIII	Hospital	PPS	
				1.00	
94.00	Total (sum of lines 91 and 93)			0	94.00
				1.00	
200.00	MEDICARE PART B ANCILLARY COSTS Part B Combined Billed Days			0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet E-1
Part I
Date/Time Prepared:
5/31/2024 12:19 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		15,400,438		11,299,454	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	09/07/2023	14,283		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)		-14,283		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)		15,386,155		11,299,454	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		245,707		94,688	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		15,631,862		11,394,142	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0101	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/31/2024 12:19 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

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 14-0101	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/31/2024 12:19 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: 14-0101

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

Worksheet G

Date/Time Prepared:
5/31/2024 12:19 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	43,620,881	0	0	0	1.00
2.00	Temporary investments	26,957,878	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	21,529,967	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,837,970	0	0	0	7.00
8.00	Prepaid expenses	3,935,058	0	0	0	8.00
9.00	Other current assets	5,345,824	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)	104,227,578	0	0	0	11.00
FIXED ASSETS						
12.00	Land	10,978,282	0	0	0	12.00
13.00	Land improvements	9,193,279	0	0	0	13.00
14.00	Accumulated depreciation	-6,498,497	0	0	0	14.00
15.00	Buildings	116,978,336	0	0	0	15.00
16.00	Accumulated depreciation	-56,990,614	0	0	0	16.00
17.00	Leasehold improvements	2,342,649	0	0	0	17.00
18.00	Accumulated depreciation	-95,431	0	0	0	18.00
19.00	Fixed equipment	55,257,429	0	0	0	19.00
20.00	Accumulated depreciation	-26,260,507	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	105,630,906	0	0	0	23.00
24.00	Accumulated depreciation	-80,032,340	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	3,568,885	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	134,072,377	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	104,512,020	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	18,805,779	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	123,317,799	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	361,617,754	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	0	0	0	0	37.00
38.00	Salaries, wages, and fees payable	22,600,265	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,053,300	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	20,401,376	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	45,054,941	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	84,620,007	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	18,226,854	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	102,846,861	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	147,901,802	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	213,715,952				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)	213,715,952	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	361,617,754	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0101

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

Worksheet G-1

Date/Time Prepared:
5/31/2024 12:19 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		194,081,248		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		19,434,188				2.00
3.00	Total (sum of line 1 and line 2)		213,515,436		0		3.00
4.00	NET ASSETS RELEASED FROM RESTRICTION	129,832		0		0	4.00
5.00	INVESTMENT RETURN	387,783		0		0	5.00
6.00	PRIOR PERIOD ADJUSTMENT	76,007		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)		593,622		0		10.00
11.00	Subtotal (line 3 plus line 10)		214,109,058		0		11.00
12.00	NET ASSETS RELEASED FROM RESTRICTION	393,106		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)		393,106		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		213,715,952		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	NET ASSETS RELEASED FROM RESTRICTION		0				4.00
5.00	INVESTMENT RETURN		0				5.00
6.00	PRIOR PERIOD ADJUSTMENT		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	NET ASSETS RELEASED FROM RESTRICTION		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: 14-0101

Period:
From 01/01/2023
To 12/31/2023Worksheet G-2
Parts I & II
Date/Time Prepared:
5/31/2024 12:19 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	28,577,057		28,577,057	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	28,577,057		28,577,057	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,070,455		5,070,455	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)	5,070,455		5,070,455	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	33,647,512		33,647,512	17.00
18.00	Ancillary services	139,039,215	518,654,656	657,693,871	18.00
19.00	Outpatient services	19,576,957	131,110,866	150,687,823	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PRIVATE OFFICES	8,578	94,003,652	94,012,230	27.00
27.01	PROFESSIONAL CHARGES	319,943	6,447,688	6,767,631	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	192,592,205	750,216,862	942,809,067	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		230,166,568		29.00
30.00	OTHER EXPENSE	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	OTHER EXPENSE	917,966			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)		917,966		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		229,248,602		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0101

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

Worksheet G-3

Date/Time Prepared:
5/31/2024 12:19 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	942,809,067	1.00
2.00	Less contractual allowances and discounts on patients' accounts	721,307,120	2.00
3.00	Net patient revenues (line 1 minus line 2)	221,501,947	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	229,248,602	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,746,655	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	12,899,409	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	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	15,532,609	24.00
24.01	NONOPERATING INCOME	-183,460	24.01
24.02	NET CHANGE IN FAIR VALUE OF INTEREST	108,762	24.02
24.03	NET ASSETS RELEASED FROM RESTRICTION	263,274	24.03
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	28,620,594	25.00
26.00	Total (line 5 plus line 25)	20,873,939	26.00
27.00	NET STLMTS FOR DERIVATIVE INSTRUMENT	-13,829	27.00
27.01	CONTRIBUTORY EXPENSE	1,453,621	27.01
27.02	ROUNDING	-41	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	1,439,751	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	19,434,188	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0101	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/31/2024 12:19 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,125,520	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		27,193	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)		36.93	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,152,713	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