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: 14-0184	Period: From 05/01/2022 To 01/13/2023	Worksheet S Parts I-III Date/Time Prepared: 8/28/2023 9:39 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 8/28/2023 Time: 9:39 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HEARTLAND REGIONAL MEDICAL CENTER (14-0184) for the cost reporting period beginning 05/01/2022 and ending 01/13/2023 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	Hank Kunath		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	Hank Kunath			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	111,478	-107	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	111,478	-107	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet S-2 Part I Date/Time Prepared: 8/28/2023 9:39 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 917 WEST MAIN ST	PO Box:			1.00
2.00	City: MARION	State: IL	Zip Code: 62959	County: WILLIAMSON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	HEARTLAND REGIONAL MEDICAL CENTER	140184	16060	1	07/01/1996	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	HEARTLAND REGIONAL MEDICAL CENTER	14U184	16060		03/23/1999	N	P	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)	05/01/2022	01/13/2023	20.00
21.00	Type of Control (see instructions)	4		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet S-2 Part I Date/Time Prepared: 8/28/2023 9:39 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	82	0	0	0	609	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	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.				58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0184	Period: From 05/01/2022 To 01/13/2023	Worksheet S-2 Part I Date/Time Prepared: 8/28/2023 9:39 am

		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	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet S-2 Part I Date/Time Prepared: 8/28/2023 9:39 am

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

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		1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)		
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?	N	68.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	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.		0	88.00

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

			1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			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: 14-0184	Period: From 05/01/2022 To 01/13/2023	Worksheet S-2 Part I Date/Time Prepared: 8/28/2023 9:39 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	184,014	4,651,577	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0776	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: QUORUM HEALTH	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 10101	141.00
142.00	Street: 1573 MALLORY LANE	PO Box:		142.00
143.00	City: BRENTWOOD	State: TN	Zip Code: 37027	143.00

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

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

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						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N		155.00
156.00	Subprovider - IPF	N	N	N	N		156.00
157.00	Subprovider - IRF	N	N	N	N		157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N		159.00
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00
161.00	CMHC		N	N	N		161.00
						1.00	
	Multicampus						
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet S-2 Part II | Date/Time Prepared: 8/28/2023 9:39 am

		Y/N	Date	
		1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE			
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	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)	Y	05/17/2023	Y	05/17/2023	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet S-2 Part II Date/Time Prepared: 8/28/2023 9:39 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			Y	12/31/2022	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	HEATHER		MANGEOT		41.00
42.00	Enter the employer/company name of the cost report preparer	QUORUM HEALTH CORP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-390-3353		HMANGEOT02@QHCUS.COM		43.00

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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.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet S-3 Part I | Date/Time Prepared: 8/28/2023 9:39 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	76	19,608	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		76	19,608	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	18	4,644	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		94	24,252	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		94				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet S-3 Part I | Date/Time Prepared: 8/28/2023 9:39 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,651	58	3,745			1.00
2.00	HMO and other (see instructions)	828	609				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)	1,651	58	3,745			7.00
8.00	INTENSIVE CARE UNIT	206	24	586			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		0	0			13.00
14.00	Total (see instructions)	1,857	82	4,331	0.00	235.43	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						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	235.43	27.00
28.00	Observation Bed Days		0	658			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet S-3 Part I | Date/Time Prepared: 8/28/2023 9:39 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	513	23	1,206	1.00
2.00	HMO and other (see instructions)			183	175		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	513	23	1,206	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: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet S-3 Part II Date/Time Prepared: 8/28/2023 9:39 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	13,574,691	0	13,574,691	343,753.00	39.49	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		50,539	-25,872	24,667	538.00	45.85	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		730,660	0	730,660	8,893.00	82.16	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		118,847	0	118,847	714.00	166.45	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		889,245	0	889,245	11,809.00	75.30	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)		3,509,054	0	3,509,054			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		10,430	0	10,430			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		106,468	0	106,468			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
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet S-3 Part II Date/Time Prepared: 8/28/2023 9:39 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	121,455	0	121,455	4,855.00	25.02	26.00
27.00	Administrative & General	5.00	1,756,467	-24,667	1,731,800	30,381.00	57.00	27.00
28.00	Administrative & General under contract (see inst.)		208,650	0	208,650	1,517.00	137.54	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	348,558	0	348,558	9,932.00	35.09	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	694,912	0	694,912	14,642.00	47.46	38.00
39.00	Central Services and Supply	14.00	175,655	0	175,655	8,617.00	20.38	39.00
40.00	Pharmacy	15.00	602,790	0	602,790	13,972.00	43.14	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet S-3 Part III Date/Time Prepared: 8/28/2023 9:39 am

		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)		13,783,341	0	13,783,341	345,270.00	39.92	1.00
2.00	Excluded area salaries (see instructions)		50,539	-25,872	24,667	538.00	45.85	2.00
3.00	Subtotal salaries (line 1 minus line 2)		13,732,802	25,872	13,758,674	344,732.00	39.91	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,738,752	0	1,738,752	21,416.00	81.19	4.00
5.00	Subtotal wage-related costs (see inst.)		3,615,522	0	3,615,522	0.00	26.28	5.00
6.00	Total (sum of lines 3 thru 5)		19,087,076	25,872	19,112,948	366,148.00	52.20	6.00
7.00	Total overhead cost (see instructions)		3,908,487	-24,667	3,883,820	83,916.00	46.28	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet S-3 Part IV Date/Time Prepared: 8/28/2023 9:39 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	67,648	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)	2,181,792	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	5,868	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	6,519	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-58	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	4,291	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	156,967	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	776,070	17.00
18.00	Medicare Taxes - Employers Portion Only	181,500	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	82,334	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,462,931	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: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet S-3 Part V Date/Time Prepared: 8/28/2023 9:39 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	730,660	3,462,931	1.00
2.00	Hospital	730,660	3,462,931	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	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet S-10 | Date/Time Prepared: 8/28/2023 9:39 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.130052	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,507,637	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	4,145,178	5.00
6.00	Medicaid charges	82,112,442	6.00
7.00	Medicaid cost (line 1 times line 6)	10,678,887	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,026,072	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,026,072	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,040,032	0	2,040,032	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	265,310	0	265,310	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	265,310	0	265,310	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,490,705	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	269,418	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	414,489	27.01
28.00	Non-Medicare bad debt expense (see instructions)	4,076,216	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	675,191	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	940,501	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,966,573	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet A | Date/Time Prepared: 8/28/2023 9:39 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		974,551	974,551	900,759	1,875,310	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,045,719	2,045,719	11,175	2,056,894	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	121,455	89,717	211,172	2,462,472	2,673,644	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,756,467	-61,555,539	-59,799,072	-3,566,887	-63,365,959	5.00
7.00	00700	OPERATION OF PLANT	348,558	2,057,981	2,406,539	-23,635	2,382,904	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	116,605	116,605	0	116,605	8.00
9.00	00900	HOUSEKEEPING	0	963,022	963,022	0	963,022	9.00
10.00	01000	DIETARY	0	995,530	995,530	-489,283	506,247	10.00
11.00	01100	CAFETERIA	0	0	0	489,283	489,283	11.00
13.00	01300	NURSING ADMINISTRATION	694,912	420,456	1,115,368	0	1,115,368	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	175,655	4,256,380	4,432,035	-3,890,178	541,857	14.00
15.00	01500	PHARMACY	602,790	1,135,138	1,737,928	-944,684	793,244	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	107,906	107,906	0	107,906	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,604,809	1,466,562	3,071,371	0	3,071,371	30.00
31.00	03100	INTENSIVE CARE UNIT	786,690	676,786	1,463,476	-8,240	1,455,236	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,890,362	2,308,872	4,199,234	366,594	4,565,828	50.00
51.00	05100	RECOVERY ROOM	254,310	21,796	276,106	-276,106	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,411,514	1,411,514	0	1,411,514	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	647,514	727,548	1,375,062	0	1,375,062	54.00
54.01	05401	ULTRASOUND	124,456	37,784	162,240	0	162,240	54.01
56.00	05600	RADIOISOTOPE	141,857	132,673	274,530	-72,134	202,396	56.00
57.00	05700	CT SCAN	223,896	127,634	351,530	0	351,530	57.00
58.00	05800	MRI	84,173	78,608	162,781	0	162,781	58.00
60.00	06000	LABORATORY	954,423	1,564,458	2,518,881	-177,055	2,341,826	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	137,977	137,977	62.00
65.00	06500	RESPIRATORY THERAPY	433,486	330,760	764,246	-1,838	762,408	65.00
66.00	06600	PHYSICAL THERAPY	321,459	50,798	372,257	5,477	377,734	66.00
67.00	06700	OCCUPATIONAL THERAPY	98,344	8,113	106,457	24,894	131,351	67.00
68.00	06800	SPEECH PATHOLOGY	38,036	6,250	44,286	-30,371	13,915	68.00
69.00	06900	ELECTROCARDIOLOGY	939,248	898,213	1,837,461	-155,639	1,681,822	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	979,209	979,209	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,048,911	3,048,911	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,016,818	1,016,818	73.00
74.00	07400	RENAL DIALYSIS	0	140,959	140,959	0	140,959	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	152,656	152,656	0	152,656	76.01
76.03	03951	WOUND CARE	44,579	10,300	54,879	0	54,879	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,236,673	1,176,103	2,412,776	65,752	2,478,528	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	50,539	15,213	65,752	-65,752	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,574,691	-37,048,934	-23,474,243	-192,481	-23,666,724	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,784	5,784	0	5,784	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	0	0	0	0	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	192,481	192,481	194.01
194.02	07952	UNUSED SPACE	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	13,574,691	-37,043,150	-23,468,459	0	-23,468,459	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet A | Date/Time Prepared: 8/28/2023 9:39 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	308,347	2,183,657		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	71,558	2,128,452		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-559	2,673,085		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	78,946,453	15,580,494		5.00
7.00	00700	OPERATION OF PLANT	-11,169	2,371,735		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	116,605		8.00
9.00	00900	HOUSEKEEPING	0	963,022		9.00
10.00	01000	DIETARY	0	506,247		10.00
11.00	01100	CAFETERIA	-78,322	410,961		11.00
13.00	01300	NURSING ADMINISTRATION	-950	1,114,418		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	541,857		14.00
15.00	01500	PHARMACY	0	793,244		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	107,906		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,104,088	1,967,283		30.00
31.00	03100	INTENSIVE CARE UNIT	-142,283	1,312,953		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-536,471	4,029,357		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	-1,357,587	53,927		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-30,479	1,344,583		54.00
54.01	05401	ULTRASOUND	0	162,240		54.01
56.00	05600	RADIOISOTOPE	0	202,396		56.00
57.00	05700	CT SCAN	0	351,530		57.00
58.00	05800	MRI	0	162,781		58.00
60.00	06000	LABORATORY	0	2,341,826		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	137,977		62.00
65.00	06500	RESPIRATORY THERAPY	0	762,408		65.00
66.00	06600	PHYSICAL THERAPY	0	377,734		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	131,351		67.00
68.00	06800	SPEECH PATHOLOGY	0	13,915		68.00
69.00	06900	ELECTROCARDIOLOGY	-155,719	1,526,103		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	979,209		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,048,911		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,016,818		73.00
74.00	07400	RENAL DIALYSIS	0	140,959		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	152,656		76.01
76.03	03951	WOUND CARE	0	54,879		76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-562,500	1,916,028		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,346,231	51,679,507		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,784		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	SENIOR CIRCLE	0	0		193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0		194.00
194.01	07953	MARKETING	0	192,481		194.01
194.02	07952	UNUSED SPACE	0	0		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	75,346,231	51,877,772		200.00

RECLASSIFICATIONS | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet A-6 | Date/Time Prepared: 8/28/2023 9:39 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,462,472		1.00
	TOTALS		0	2,462,472		
	B - OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	28,832		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		0	28,832		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	166,589		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	734,170		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	11,175		3.00
	TOTALS		0	911,934		
	E - MARKETING DEPARTMENT					
1.00	MARKETING	194.01	24,667	167,814		1.00
	TOTALS		24,667	167,814		
	F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	950,377		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,048,911		2.00
3.00	OPERATING ROOM	50.00	0	53,375		3.00
	TOTALS		0	4,052,663		
	G - DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,016,818		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	1,016,818		
	I - PT, OT AND SP COST					
1.00	PHYSICAL THERAPY	66.00	9,213	0		1.00
2.00	OCCUPATIONAL THERAPY	67.00	16,642	8,252		2.00
	TOTALS		25,855	8,252		
	K - MISCELLANEOUS DEPARTMENTS					
1.00	OPERATING ROOM	50.00	293,388	21,796		1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	6,428	131,549		2.00
3.00	EMERGENCY	91.00	50,539	15,213		3.00
	TOTALS		350,355	168,558		
	M - PORTION OF DIETARY COST TO CAFETERIA					
1.00	CAFETERIA	11.00	0	489,283		1.00
	TOTALS		0	489,283		
500.00	Grand Total: Increases		400,877	9,306,626		500.00

RECLASSIFICATIONS | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet A-6 | Date/Time Prepared: 8/28/2023 9:39 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,462,472	0		1.00
	TOTALS		0	2,462,472			
	B - OXYGEN COSTS						
1.00	OPERATION OF PLANT	7.00	0	23,635	0		1.00
2.00	OPERATING ROOM	50.00	0	1,965	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	1,838	0		3.00
4.00	ELECTROCARDIOLOGY	69.00	0	1,394	0		4.00
	TOTALS		0	28,832			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	911,934	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	911,934			
	E - MARKETING DEPARTMENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	24,667	167,814	0		1.00
	TOTALS		24,667	167,814			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,890,178	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	8,240	0		2.00
3.00	ELECTROCARDIOLOGY	69.00	0	154,245	0		3.00
	TOTALS		0	4,052,663			
	G - DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	944,684	0		1.00
2.00	RADIOISOTOPE	56.00	0	72,134	0		2.00
	TOTALS		0	1,016,818			
	I - PT, OT AND SP COST						
1.00	PHYSICAL THERAPY	66.00	0	3,736	0		1.00
2.00	SPEECH PATHOLOGY	68.00	25,855	4,516	0		2.00
	TOTALS		25,855	8,252			
	K - MISCELLANEOUS DEPARTMENTS						
1.00	RECOVERY ROOM	51.00	254,310	21,796	0		1.00
2.00	LABORATORY	60.00	45,506	131,549	0		2.00
3.00	AMBULANCE SERVICES	95.00	50,539	15,213	0		3.00
	TOTALS		350,355	168,558			
	M - PORTION OF DIETARY COST TO CAFETERIA						
1.00	DIETARY	10.00	0	489,283	0		1.00
	TOTALS		0	489,283			
500.00	Grand Total: Decreases		400,877	9,306,626			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet A-7 Part I | Date/Time Prepared: 8/28/2023 9:39 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,402,888	0	0	0	0	1.00
2.00	Land Improvements	822,554	0	0	0	0	2.00
3.00	Buildings and Fixtures	53,694,469	0	0	0	0	3.00
4.00	Building Improvements	28,375,492	0	0	0	0	4.00
5.00	Fixed Equipment	2,395,396	0	0	0	0	5.00
6.00	Movable Equipment	5,235,878	0	0	0	0	6.00
7.00	HIT designated Assets	6,012,893	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	97,939,570	0	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	97,939,570	0	0	0	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,402,888	0	1.00
2.00	Land Improvements	822,554	0	2.00
3.00	Buildings and Fixtures	53,694,469	0	3.00
4.00	Building Improvements	28,375,492	0	4.00
5.00	Fixed Equipment	2,395,396	0	5.00
6.00	Movable Equipment	5,235,878	0	6.00
7.00	HIT designated Assets	6,012,893	0	7.00
8.00	Subtotal (sum of lines 1-7)	97,939,570	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	97,939,570	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet A-7 Part II | Date/Time Prepared: 8/28/2023 9:39 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	974,551	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,045,719	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,020,270	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	974,551	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,045,719	2.00
3.00	Total (sum of lines 1-2)	0	3,020,270	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet A-7 Part III Date/Time Prepared: 8/28/2023 9:39 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	84,295,403	0	84,295,403	0.860688	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,644,167	0	13,644,167	0.139312	0	2.00
3.00	Total (sum of lines 1-2)	97,939,570	0	97,939,570	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,097,159	-6,606	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,791,779	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,888,938	-6,606	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	192,345	166,589	734,170	0	2,183,657	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	325,498	11,175	0	0	2,128,452	2.00
3.00	Total (sum of lines 1-2)	517,843	177,764	734,170	0	4,312,109	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet A-8 | Date/Time Prepared: 8/28/2023 9:39 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-6,606	CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-16,024	ADMINISTRATIVE & GENERAL	5.00	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	-3,889,127			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	2,910,847			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-78,322	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	0	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)	B	0	NURSING ADMINISTRATION	13.00	0	19.00
20.00	Vending machines	B	-1,736	ADMINISTRATIVE & GENERAL	5.00	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	A	122,608	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-248,414	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS REVENUE	B	-48,085	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	INSERVICE EDUCATION	B	-950	NURSING ADMINISTRATION	13.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet A-8 | Date/Time Prepared: 8/28/2023 9:39 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	PATIENT PHONE SALARIES AND WAGES	A	-2,139	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PATIENT PHONE BENEFIT EXPENSE	A	-559	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04	PATIENT PHONE DEPRECIATION EXPENSE	A	-5,373	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.04
33.05	PATIENT TV DEPRECIATION EXPENSE	A	-153	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.05
33.06	MARKETING EXPENSES	A	-8,367	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	EMPLOYEE GIFTS	A	-1,179	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	LOBBYING EXPENSE	A	-20,167	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	LEGAL FEES	A	-247,381	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	CHARITABLE CONTRIBUTIONS	A	-57,443	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	LOSS ON SALE OF ENTITY	A	81,079,379	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	ILLINOIS PROVIDER TAX	A	-3,981,295	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	CRNA COST	A	0	ANESTHESIOLOGY	53.00	0	33.13
33.14	NON-ALLOWABLE LEGAL EXPENSES	A	-82,365	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	MISC NON-PATIENT REV	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	SPECIAL EVENTS	A	-4,569	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	PENALTIES	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	LATE CHARGES	A	-55,180	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	PATIENT TV CABLE EXPENSE	A	-11,169	OPERATION OF PLANT	7.00	0	33.19
33.20	TRAINING REVENUE	B	0	NURSING ADMINISTRATION	13.00	0	33.20
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		75,346,231				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet A-8-1 | Date/Time Prepared: 8/28/2023 9:39 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00			0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	POOLED ALLOCATION OF NON-CAP	911,946	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	192,345	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	325,498	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL FUNCTIONAL ALLOC	739,469	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	4,835,591	1,880,750	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	2,213,252	4.03
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,004,849	4,094,002	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B	QUORUM HEALTH C	100.00	QUORUM HEALTH C	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-0184	Period: From 05/01/2022 To 01/13/2023	Worksheet A-8-1 Date/Time Prepared: 8/28/2023 9:39 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	911,946	0		2.00
3.00	192,345	11		3.00
4.00	325,498	11		4.00
4.01	739,469	0		4.01
4.02	2,954,841	0		4.02
4.03	-2,213,252	0		4.03
5.00	2,910,847			5.00

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

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

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

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

6.00	HOSPITAL CORPOR		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet A-8-2 | Date/Time Prepared: 8/28/2023 9:39 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,104,088	1,104,088	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	142,283	142,283	0	0	0	2.00
3.00	50.00	OPERATING ROOM	536,471	536,471	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	1,357,587	1,357,587	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	30,479	30,479	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	155,719	155,719	0	0	0	6.00
7.00	91.00	EMERGENCY	562,500	562,500	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,889,127	3,889,127	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			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	30.00	ADULTS & PEDIATRICS	0	0	0	1,104,088		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	142,283		2.00
3.00	50.00	OPERATING ROOM	0	0	0	536,471		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	1,357,587		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	30,479		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	155,719		6.00
7.00	91.00	EMERGENCY	0	0	0	562,500		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,889,127		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet B Part I Date/Time Prepared: 8/28/2023 9:39 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,183,657	2,183,657				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,128,452		2,128,452			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,673,085	12,072	11,766	2,696,923		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,580,494	238,283	232,259	347,167	16,398,203	5.00
7.00	00700	OPERATION OF PLANT	2,371,735	511,180	498,260	69,874	3,451,049	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	116,605	4,957	4,831	0	126,393	8.00
9.00	00900	HOUSEKEEPING	963,022	13,441	13,101	0	989,564	9.00
10.00	01000	DIETARY	506,247	36,624	35,698	0	578,569	10.00
11.00	01100	CAFETERIA	410,961	41,391	40,345	0	492,697	11.00
13.00	01300	NURSING ADMINISTRATION	1,114,418	57,060	55,617	139,306	1,366,401	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	541,857	23,294	22,705	35,213	623,069	14.00
15.00	01500	PHARMACY	793,244	20,596	20,075	120,839	954,754	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	107,906	34,276	33,409	0	175,591	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,967,283	272,749	265,853	321,710	2,827,595	30.00
31.00	03100	INTENSIVE CARE UNIT	1,312,953	122,354	119,261	157,705	1,712,273	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,029,357	205,146	199,960	437,772	4,872,235	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	53,927	2,838	2,766	0	59,531	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,344,583	72,849	71,007	129,805	1,618,244	54.00
54.01	05401	ULTRASOUND	162,240	20,845	20,318	24,949	228,352	54.01
56.00	05600	RADIOISOTOPE	202,396	6,905	6,731	28,438	244,470	56.00
57.00	05700	CT SCAN	351,530	12,012	11,708	44,884	420,134	57.00
58.00	05800	MRI	162,781	12,761	12,438	16,874	204,854	58.00
60.00	06000	LABORATORY	2,341,826	47,347	46,150	182,207	2,617,530	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	137,977	2,518	2,455	1,289	144,239	62.00
65.00	06500	RESPIRATORY THERAPY	762,408	10,842	10,568	86,899	870,717	65.00
66.00	06600	PHYSICAL THERAPY	377,734	65,404	63,751	66,288	573,177	66.00
67.00	06700	OCCUPATIONAL THERAPY	131,351	1,649	1,607	23,051	157,658	67.00
68.00	06800	SPEECH PATHOLOGY	13,915	929	906	2,442	18,192	68.00
69.00	06900	ELECTROCARDIOLOGY	1,526,103	41,871	40,812	188,287	1,797,073	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	979,209	0	0	0	979,209	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,048,911	0	0	0	3,048,911	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,016,818	0	0	0	1,016,818	73.00
74.00	07400	RENAL DIALYSIS	140,959	3,338	3,253	0	147,550	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	152,656	23,543	22,948	0	199,147	76.01
76.03	03951	WOUND CARE	54,879	28,120	27,409	8,937	119,345	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,916,028	95,313	92,903	258,042	2,362,286	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51,679,507	2,042,507	1,990,870	2,691,978	51,395,830	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,755	6,584	0	13,339	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,784	131,907	128,573	0	266,264	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	0	2,488	2,425	0	4,913	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	192,481	0	0	4,945	197,426	194.01
194.02	07952	UNUSED SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	51,877,772	2,183,657	2,128,452	2,696,923	51,877,772	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet B Part I Date/Time Prepared: 8/28/2023 9:39 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,398,203					5.00
7.00	00700	OPERATION OF PLANT	1,595,030	5,046,079				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	58,417	17,587	202,397			8.00
9.00	00900	HOUSEKEEPING	457,364	47,691	0	1,494,619		9.00
10.00	01000	DIETARY	267,407	129,953	0	38,996	1,014,925	10.00
11.00	01100	CAFETERIA	227,718	146,866	0	44,071	0	11.00
13.00	01300	NURSING ADMINISTRATION	631,533	202,464	0	60,755	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	287,974	82,652	0	24,802	0	14.00
15.00	01500	PHARMACY	441,275	73,079	0	21,929	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	81,156	121,620	0	36,495	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,306,878	967,788	44,394	290,409	600,741	30.00
31.00	03100	INTENSIVE CARE UNIT	791,390	434,146	24,350	130,277	89,784	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,251,892	727,914	26,539	218,430	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	27,514	10,070	0	3,022	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	747,931	258,488	19,272	77,566	0	54.00
54.01	05401	ULTRASOUND	105,541	73,965	0	22,195	0	54.01
56.00	05600	RADIOISOTOPE	112,991	24,501	0	7,352	0	56.00
57.00	05700	CT SCAN	194,180	42,620	0	12,789	0	57.00
58.00	05800	MRI	94,681	45,280	0	13,587	0	58.00
60.00	06000	LABORATORY	1,209,788	167,999	0	50,413	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	66,665	8,935	0	2,681	0	62.00
65.00	06500	RESPIRATORY THERAPY	402,434	38,472	0	11,544	0	65.00
66.00	06600	PHYSICAL THERAPY	264,915	232,072	11,029	69,639	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	72,867	5,851	0	1,756	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,408	3,298	0	990	0	68.00
69.00	06900	ELECTROCARDIOLOGY	830,584	148,568	14,981	44,582	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	452,578	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,409,167	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	469,960	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	68,196	11,843	147	3,554	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	92,043	83,539	834	25,068	0	76.01
76.03	03951	WOUND CARE	55,160	99,778	4,218	29,941	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,091,818	338,197	55,924	101,485	92,176	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,175,455	4,545,236	201,688	1,344,328	782,701	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,165	23,970	0	7,193	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	123,064	468,044	709	140,449	232,224	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	2,271	8,829	0	2,649	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	91,248	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,398,203	5,046,079	202,397	1,494,619	1,014,925	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet B Part I | Date/Time Prepared: 8/28/2023 9:39 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	911,352					11.00
13.00	01300	NURSING ADMINISTRATION	44,701	2,305,854				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	26,295	0	1,044,792			14.00
15.00	01500	PHARMACY	42,651	0	4,564	1,538,252		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	236	0	415,098	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	138,113	435,263	24,356	0	20,895	30.00
31.00	03100	INTENSIVE CARE UNIT	47,330	213,369	23,005	0	3,909	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	161,910	592,282	134,117	0	74,663	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	12,459	0	12,754	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,570	175,621	3,552	0	11,621	54.00
54.01	05401	ULTRASOUND	8,958	33,755	670	0	3,469	54.01
56.00	05600	RADIOISOTOPE	8,379	38,475	526	0	7,998	56.00
57.00	05700	CT SCAN	19,610	60,726	6,032	0	31,921	57.00
58.00	05800	MRI	5,482	22,830	452	0	6,153	58.00
60.00	06000	LABORATORY	113,468	0	99,212	0	72,671	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	807	62.00
65.00	06500	RESPIRATORY THERAPY	36,456	117,572	10,233	0	9,559	65.00
66.00	06600	PHYSICAL THERAPY	29,459	0	1,580	0	6,005	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,938	0	0	0	2,088	67.00
68.00	06800	SPEECH PATHOLOGY	178	0	0	0	221	68.00
69.00	06900	ELECTROCARDIOLOGY	78,795	254,747	31,089	0	46,288	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	223,977	0	8,811	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	410,137	0	28,971	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,538,252	19,856	73.00
74.00	07400	RENAL DIALYSIS	0	0	614	0	772	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	345	0	881	76.01
76.03	03951	WOUND CARE	3,744	12,091	216	0	153	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	80,666	349,123	57,420	0	44,632	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	909,703	2,305,854	1,044,792	1,538,252	415,098	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	0	0	0	0	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	1,649	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	911,352	2,305,854	1,044,792	1,538,252	415,098	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet B Part I | Date/Time Prepared: 8/28/2023 9:39 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	6,656,432	0	6,656,432		30.00
31.00	03100	INTENSIVE CARE UNIT	3,469,833	0	3,469,833		31.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	9,059,982	0	9,059,982		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	125,350	0	125,350		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,965,865	0	2,965,865		54.00
54.01	05401	ULTRASOUND	476,905	0	476,905		54.01
56.00	05600	RADIOISOTOPE	444,692	0	444,692		56.00
57.00	05700	CT SCAN	788,012	0	788,012		57.00
58.00	05800	MRI	393,319	0	393,319		58.00
60.00	06000	LABORATORY	4,331,081	0	4,331,081		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	223,327	0	223,327		62.00
65.00	06500	RESPIRATORY THERAPY	1,496,987	0	1,496,987		65.00
66.00	06600	PHYSICAL THERAPY	1,187,876	0	1,187,876		66.00
67.00	06700	OCCUPATIONAL THERAPY	250,158	0	250,158		67.00
68.00	06800	SPEECH PATHOLOGY	31,287	0	31,287		68.00
69.00	06900	ELECTROCARDIOLOGY	3,246,707	0	3,246,707		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,664,575	0	1,664,575		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,897,186	0	4,897,186		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,044,886	0	3,044,886		73.00
74.00	07400	RENAL DIALYSIS	232,676	0	232,676		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	401,857	0	401,857		76.01
76.03	03951	WOUND CARE	324,646	0	324,646		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	4,573,727	0	4,573,727		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,287,366	0	50,287,366		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	50,667	0	50,667		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,230,754	0	1,230,754		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	SENIOR CIRCLE	18,662	0	18,662		193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0		194.00
194.01	07953	MARKETING	290,323	0	290,323		194.01
194.02	07952	UNUSED SPACE	0	0	0		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	51,877,772	0	51,877,772		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet B Part II Date/Time Prepared: 8/28/2023 9:39 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,072	11,766	23,838	23,838	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	238,283	232,259	470,542	3,069	5.00
7.00	00700	OPERATION OF PLANT	0	511,180	498,260	1,009,440	618	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,957	4,831	9,788	0	8.00
9.00	00900	HOUSEKEEPING	0	13,441	13,101	26,542	0	9.00
10.00	01000	DIETARY	0	36,624	35,698	72,322	0	10.00
11.00	01100	CAFETERIA	0	41,391	40,345	81,736	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	57,060	55,617	112,677	1,231	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	23,294	22,705	45,999	311	14.00
15.00	01500	PHARMACY	0	20,596	20,075	40,671	1,068	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	34,276	33,409	67,685	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	272,749	265,853	538,602	2,844	30.00
31.00	03100	INTENSIVE CARE UNIT	0	122,354	119,261	241,615	1,394	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	205,146	199,960	405,106	3,868	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	2,838	2,766	5,604	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	72,849	71,007	143,856	1,147	54.00
54.01	05401	ULTRASOUND	0	20,845	20,318	41,163	221	54.01
56.00	05600	RADIOISOTOPE	0	6,905	6,731	13,636	251	56.00
57.00	05700	CT SCAN	0	12,012	11,708	23,720	397	57.00
58.00	05800	MRI	0	12,761	12,438	25,199	149	58.00
60.00	06000	LABORATORY	0	47,347	46,150	93,497	1,611	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,518	2,455	4,973	11	62.00
65.00	06500	RESPIRATORY THERAPY	0	10,842	10,568	21,410	768	65.00
66.00	06600	PHYSICAL THERAPY	0	65,404	63,751	129,155	586	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,649	1,607	3,256	204	67.00
68.00	06800	SPEECH PATHOLOGY	0	929	906	1,835	22	68.00
69.00	06900	ELECTROCARDIOLOGY	0	41,871	40,812	82,683	1,664	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
74.00	07400	RENAL DIALYSIS	0	3,338	3,253	6,591	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	23,543	22,948	46,491	0	76.01
76.03	03951	WOUND CARE	0	28,120	27,409	55,529	79	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	95,313	92,903	188,216	2,281	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,042,507	1,990,870	4,033,377	23,794	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,755	6,584	13,339	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	131,907	128,573	260,480	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	0	2,488	2,425	4,913	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	0	44	194.01
194.02	07952	UNUSED SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,183,657	2,128,452	4,312,109	23,838	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet B Part II Date/Time Prepared: 8/28/2023 9:39 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	473,611					5.00
7.00	00700	OPERATION OF PLANT	46,068	1,056,126				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,687	3,681	15,156			8.00
9.00	00900	HOUSEKEEPING	13,210	9,982	0	49,734		9.00
10.00	01000	DIETARY	7,723	27,199	0	1,298	108,542	10.00
11.00	01100	CAFETERIA	6,577	30,739	0	1,466	0	11.00
13.00	01300	NURSING ADMINISTRATION	18,240	42,375	0	2,022	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,317	17,299	0	825	0	14.00
15.00	01500	PHARMACY	12,745	15,295	0	730	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,344	25,455	0	1,214	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,746	202,552	3,324	9,666	64,247	30.00
31.00	03100	INTENSIVE CARE UNIT	22,857	90,865	1,823	4,335	9,602	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	65,036	152,350	1,987	7,268	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	795	2,108	0	101	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,602	54,101	1,443	2,581	0	54.00
54.01	05401	ULTRASOUND	3,048	15,481	0	739	0	54.01
56.00	05600	RADIOISOTOPE	3,263	5,128	0	245	0	56.00
57.00	05700	CT SCAN	5,608	8,920	0	426	0	57.00
58.00	05800	MRI	2,735	9,477	0	452	0	58.00
60.00	06000	LABORATORY	34,941	35,162	0	1,677	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,925	1,870	0	89	0	62.00
65.00	06500	RESPIRATORY THERAPY	11,623	8,052	0	384	0	65.00
66.00	06600	PHYSICAL THERAPY	7,651	48,572	826	2,317	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,105	1,224	0	58	0	67.00
68.00	06800	SPEECH PATHOLOGY	243	690	0	33	0	68.00
69.00	06900	ELECTROCARDIOLOGY	23,989	31,095	1,122	1,483	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,071	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,700	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,574	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,970	2,479	11	118	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,658	17,484	62	834	0	76.01
76.03	03951	WOUND CARE	1,593	20,883	316	996	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	31,534	70,783	4,189	3,377	9,858	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	467,178	951,301	15,103	44,734	83,707	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	178	5,017	0	239	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,554	97,960	53	4,673	24,835	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	66	1,848	0	88	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	2,635	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	473,611	1,056,126	15,156	49,734	108,542	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet B Part II | Date/Time Prepared: 8/28/2023 9:39 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	120,518					11.00
13.00	01300	NURSING ADMINISTRATION	5,911	182,456				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,477	0	76,228			14.00
15.00	01500	PHARMACY	5,640	0	333	76,482		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	17	0	96,715	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,264	34,441	1,777	0	4,864	30.00
31.00	03100	INTENSIVE CARE UNIT	6,259	16,883	1,678	0	910	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,412	46,868	9,785	0	17,469	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	909	0	2,969	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,084	13,896	259	0	2,705	54.00
54.01	05401	ULTRASOUND	1,185	2,671	49	0	808	54.01
56.00	05600	RADIOISOTOPE	1,108	3,044	38	0	1,862	56.00
57.00	05700	CT SCAN	2,593	4,805	440	0	7,430	57.00
58.00	05800	MRI	725	1,806	33	0	1,432	58.00
60.00	06000	LABORATORY	15,005	0	7,238	0	16,916	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	188	62.00
65.00	06500	RESPIRATORY THERAPY	4,821	9,303	747	0	2,225	65.00
66.00	06600	PHYSICAL THERAPY	3,896	0	115	0	1,398	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,314	0	0	0	486	67.00
68.00	06800	SPEECH PATHOLOGY	24	0	0	0	51	68.00
69.00	06900	ELECTROCARDIOLOGY	10,420	20,157	2,268	0	10,775	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	16,341	0	2,051	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	29,926	0	6,744	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	76,482	4,622	73.00
74.00	07400	RENAL DIALYSIS	0	0	45	0	180	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	25	0	205	76.01
76.03	03951	WOUND CARE	495	957	16	0	36	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,667	27,625	4,189	0	10,389	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	120,300	182,456	76,228	76,482	96,715	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	0	0	0	0	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	218	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	120,518	182,456	76,228	76,482	96,715	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet B Part II | Date/Time Prepared: 8/28/2023 9:39 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	918,327	0	918,327		30.00
31.00	03100	INTENSIVE CARE UNIT	398,221	0	398,221		31.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	731,149	0	731,149		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	12,486	0	12,486		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	248,674	0	248,674		54.00
54.01	05401	ULTRASOUND	65,365	0	65,365		54.01
56.00	05600	RADIOISOTOPE	28,575	0	28,575		56.00
57.00	05700	CT SCAN	54,339	0	54,339		57.00
58.00	05800	MRI	42,008	0	42,008		58.00
60.00	06000	LABORATORY	206,047	0	206,047		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	9,056	0	9,056		62.00
65.00	06500	RESPIRATORY THERAPY	59,333	0	59,333		65.00
66.00	06600	PHYSICAL THERAPY	194,516	0	194,516		66.00
67.00	06700	OCCUPATIONAL THERAPY	8,647	0	8,647		67.00
68.00	06800	SPEECH PATHOLOGY	2,898	0	2,898		68.00
69.00	06900	ELECTROCARDIOLOGY	185,656	0	185,656		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	31,463	0	31,463		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	77,370	0	77,370		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	94,678	0	94,678		73.00
74.00	07400	RENAL DIALYSIS	11,394	0	11,394		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	67,759	0	67,759		76.01
76.03	03951	WOUND CARE	80,900	0	80,900		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	363,108	0	363,108		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,891,969	0	3,891,969		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,773	0	18,773		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	391,555	0	391,555		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	SENIOR CIRCLE	6,915	0	6,915		193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0		194.00
194.01	07953	MARKETING	2,897	0	2,897		194.01
194.02	07952	UNUSED SPACE	0	0	0		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	4,312,109	0	4,312,109		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet B-1 | Date/Time Prepared: 8/28/2023 9:39 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	218,519					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		218,519				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,208	1,208	13,453,236			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,845	23,845	1,731,800	-16,398,203	35,479,569	5.00
7.00	00700	OPERATION OF PLANT	51,154	51,154	348,558	0	3,451,049	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	496	496	0	0	126,393	8.00
9.00	00900	HOUSEKEEPING	1,345	1,345	0	0	989,564	9.00
10.00	01000	DIETARY	3,665	3,665	0	0	578,569	10.00
11.00	01100	CAFETERIA	4,142	4,142	0	0	492,697	11.00
13.00	01300	NURSING ADMINISTRATION	5,710	5,710	694,912	0	1,366,401	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,331	2,331	175,655	0	623,069	14.00
15.00	01500	PHARMACY	2,061	2,061	602,790	0	954,754	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,430	3,430	0	0	175,591	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,294	27,294	1,604,809	0	2,827,595	30.00
31.00	03100	INTENSIVE CARE UNIT	12,244	12,244	786,690	0	1,712,273	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,529	20,529	2,183,750	0	4,872,235	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	284	284	0	0	59,531	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,290	7,290	647,514	0	1,618,244	54.00
54.01	05401	ULTRASOUND	2,086	2,086	124,456	0	228,352	54.01
56.00	05600	RADIOISOTOPE	691	691	141,857	0	244,470	56.00
57.00	05700	CT SCAN	1,202	1,202	223,896	0	420,134	57.00
58.00	05800	MRI	1,277	1,277	84,173	0	204,854	58.00
60.00	06000	LABORATORY	4,738	4,738	908,917	0	2,617,530	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	252	252	6,428	0	144,239	62.00
65.00	06500	RESPIRATORY THERAPY	1,085	1,085	433,486	0	870,717	65.00
66.00	06600	PHYSICAL THERAPY	6,545	6,545	330,672	0	573,177	66.00
67.00	06700	OCCUPATIONAL THERAPY	165	165	114,986	0	157,658	67.00
68.00	06800	SPEECH PATHOLOGY	93	93	12,181	0	18,192	68.00
69.00	06900	ELECTROCARDIOLOGY	4,190	4,190	939,248	0	1,797,073	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	979,209	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,048,911	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,016,818	73.00
74.00	07400	RENAL DIALYSIS	334	334	0	0	147,550	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,356	2,356	0	0	199,147	76.01
76.03	03951	WOUND CARE	2,814	2,814	44,579	0	119,345	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	9,538	9,538	1,287,212	0	2,362,286	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	204,394	204,394	13,428,569	-16,398,203	34,997,627	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	676	676	0	0	13,339	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,200	13,200	0	0	266,264	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	249	249	0	0	4,913	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	24,667	0	197,426	194.01
194.02	07952	UNUSED SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,183,657	2,128,452	2,696,923		16,398,203	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.992985	9.740352	0.200466		0.462187	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			23,838		473,611	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001772		0.013349	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet B-1 | Date/Time Prepared: 8/28/2023 9:39 am

	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	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet B-1 | Date/Time Prepared: 8/28/2023 9:39 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	142,312					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	496	275,929				8.00
9.00	00900	HOUSEKEEPING	1,345	0	140,471			9.00
10.00	01000	DIETARY	3,665	0	3,665	27,582		10.00
11.00	01100	CAFETERIA	4,142	0	4,142	0	20,449	11.00
13.00	01300	NURSING ADMINISTRATION	5,710	0	5,710	0	1,003	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,331	0	2,331	0	590	14.00
15.00	01500	PHARMACY	2,061	0	2,061	0	957	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,430	0	3,430	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,294	60,523	27,294	16,326	3,099	30.00
31.00	03100	INTENSIVE CARE UNIT	12,244	33,196	12,244	2,440	1,062	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,529	36,181	20,529	0	3,633	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	284	0	284	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,290	26,273	7,290	0	1,202	54.00
54.01	05401	ULTRASOUND	2,086	0	2,086	0	201	54.01
56.00	05600	RADIOISOTOPE	691	0	691	0	188	56.00
57.00	05700	CT SCAN	1,202	0	1,202	0	440	57.00
58.00	05800	MRI	1,277	0	1,277	0	123	58.00
60.00	06000	LABORATORY	4,738	0	4,738	0	2,546	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	252	0	252	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,085	0	1,085	0	818	65.00
66.00	06600	PHYSICAL THERAPY	6,545	15,036	6,545	0	661	66.00
67.00	06700	OCCUPATIONAL THERAPY	165	0	165	0	223	67.00
68.00	06800	SPEECH PATHOLOGY	93	0	93	0	4	68.00
69.00	06900	ELECTROCARDIOLOGY	4,190	20,424	4,190	0	1,768	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
74.00	07400	RENAL DIALYSIS	334	200	334	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,356	1,137	2,356	0	0	76.01
76.03	03951	WOUND CARE	2,814	5,750	2,814	0	84	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	9,538	76,242	9,538	2,505	1,810	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	128,187	274,962	126,346	21,271	20,412	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	676	0	676	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,200	967	13,200	6,311	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	249	0	249	0	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	0	37	194.01
194.02	07952	UNUSED SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,046,079	202,397	1,494,619	1,014,925	911,352	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	35.457860	0.733511	10.640054	36.796643	44.567069	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,056,126	15,156	49,734	108,542	120,518	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.421201	0.054927	0.354052	3.935248	5.893589	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: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet B-1 | Date/Time Prepared: 8/28/2023 9:39 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	8,501,671					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,098,091				14.00
15.00	01500	PHARMACY	0	22,271	944,684			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,153	0	386,670,795		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,604,809	118,848	0	19,455,371		30.00
31.00	03100	INTENSIVE CARE UNIT	786,690	112,255	0	3,640,095		31.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,183,751	654,425	0	69,692,620		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	60,792	0	11,874,946		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	647,514	17,332	0	10,819,846		54.00
54.01	05401	ULTRASOUND	124,456	3,271	0	3,230,052		54.01
56.00	05600	RADIOISOTOPE	141,857	2,568	0	7,446,725		56.00
57.00	05700	CT SCAN	223,896	29,431	0	29,721,658		57.00
58.00	05800	MRI	84,173	2,207	0	5,728,973		58.00
60.00	06000	LABORATORY	0	484,105	0	67,664,336		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	751,414		62.00
65.00	06500	RESPIRATORY THERAPY	433,486	49,931	0	8,900,796		65.00
66.00	06600	PHYSICAL THERAPY	0	7,708	0	5,591,388		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,944,304		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	205,971		68.00
69.00	06900	ELECTROCARDIOLOGY	939,248	151,700	0	43,098,347		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,092,899	0	8,203,542		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,001,280	0	26,974,813		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	944,684	18,487,985		73.00
74.00	07400	RENAL DIALYSIS	0	2,995	0	718,371		74.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	1,682	0	820,223		76.01
76.03	03951	WOUND CARE	44,579	1,055	0	142,442		76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,287,212	280,183	0	41,556,577		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,501,671	5,098,091	944,684	386,670,795		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	SENIOR CIRCLE	0	0	0	0		193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0		194.00
194.01	07953	MARKETING	0	0	0	0		194.01
194.02	07952	UNUSED SPACE	0	0	0	0		194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,305,854	1,044,792	1,538,252	415,098		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.271224	0.204938	1.628324	0.001074		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	182,456	76,228	76,482	96,715		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.021461	0.014952	0.080960	0.000250		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet C Part I Date/Time Prepared: 8/28/2023 9:39 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,656,432		6,656,432	0	6,656,432	30.00
31.00	03100	INTENSIVE CARE UNIT	3,469,833		3,469,833	0	3,469,833	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,059,982		9,059,982	0	9,059,982	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	125,350		125,350	0	125,350	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,965,865		2,965,865	0	2,965,865	54.00
54.01	05401	ULTRASOUND	476,905		476,905	0	476,905	54.01
56.00	05600	RADIOISOTOPE	444,692		444,692	0	444,692	56.00
57.00	05700	CT SCAN	788,012		788,012	0	788,012	57.00
58.00	05800	MRI	393,319		393,319	0	393,319	58.00
60.00	06000	LABORATORY	4,331,081		4,331,081	0	4,331,081	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	223,327		223,327	0	223,327	62.00
65.00	06500	RESPIRATORY THERAPY	1,496,987	0	1,496,987	0	1,496,987	65.00
66.00	06600	PHYSICAL THERAPY	1,187,876	0	1,187,876	0	1,187,876	66.00
67.00	06700	OCCUPATIONAL THERAPY	250,158	0	250,158	0	250,158	67.00
68.00	06800	SPEECH PATHOLOGY	31,287	0	31,287	0	31,287	68.00
69.00	06900	ELECTROCARDIOLOGY	3,246,707		3,246,707	0	3,246,707	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,664,575		1,664,575	0	1,664,575	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,897,186		4,897,186	0	4,897,186	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,044,886		3,044,886	0	3,044,886	73.00
74.00	07400	RENAL DIALYSIS	232,676		232,676	0	232,676	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	401,857		401,857	0	401,857	76.01
76.03	03951	WOUND CARE	324,646		324,646	0	324,646	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,573,727		4,573,727	0	4,573,727	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	994,758		994,758		994,758	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
200.00		Subtotal (see instructions)	51,282,124	0	51,282,124	0	51,282,124	200.00
201.00		Less Observation Beds	994,758		994,758		994,758	201.00
202.00		Total (see instructions)	50,287,366	0	50,287,366	0	50,287,366	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet C Part I Date/Time Prepared: 8/28/2023 9:39 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,441,092		17,441,092			30.00
31.00	03100	INTENSIVE CARE UNIT	3,640,095		3,640,095			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,556,449	53,136,171	69,692,620	0.129999	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	3,321,863	8,553,083	11,874,946	0.010556	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,301,591	9,518,255	10,819,846	0.274113	0.000000	54.00
54.01	05401	ULTRASOUND	521,592	2,708,460	3,230,052	0.147646	0.000000	54.01
56.00	05600	RADIOISOTOPE	2,255,703	5,191,022	7,446,725	0.059716	0.000000	56.00
57.00	05700	CT SCAN	6,411,160	23,310,498	29,721,658	0.026513	0.000000	57.00
58.00	05800	MRI	322,382	5,406,591	5,728,973	0.068654	0.000000	58.00
60.00	06000	LABORATORY	16,312,394	51,351,942	67,664,336	0.064008	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	449,256	302,158	751,414	0.297209	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	7,527,770	1,373,026	8,900,796	0.168186	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,569,175	3,022,213	5,591,388	0.212447	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,392,223	552,081	1,944,304	0.128662	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	138,799	67,172	205,971	0.151900	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	24,512,980	18,585,367	43,098,347	0.075333	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,505,237	3,698,305	8,203,542	0.202909	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,156,796	14,818,017	26,974,813	0.181547	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,442,280	9,045,705	18,487,985	0.164695	0.000000	73.00
74.00	07400	RENAL DIALYSIS	662,064	56,307	718,371	0.323894	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	820,223	820,223	0.489936	0.000000	76.01
76.03	03951	WOUND CARE	5,446	136,996	142,442	2.279145	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,797,588	33,758,989	41,556,577	0.110060	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	859,714	1,154,565	2,014,279	0.493853	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
200.00		Subtotal (see instructions)	140,103,649	246,567,146	386,670,795			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	140,103,649	246,567,146	386,670,795			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet C Part I Date/Time Prepared: 8/28/2023 9:39 am

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.129999	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	0.010556	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.274113	54.00
54.01	05401	ULTRASOUND	0.147646	54.01
56.00	05600	RADIOISOTOPE	0.059716	56.00
57.00	05700	CT SCAN	0.026513	57.00
58.00	05800	MRI	0.068654	58.00
60.00	06000	LABORATORY	0.064008	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.297209	62.00
65.00	06500	RESPIRATORY THERAPY	0.168186	65.00
66.00	06600	PHYSICAL THERAPY	0.212447	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.128662	67.00
68.00	06800	SPEECH PATHOLOGY	0.151900	68.00
69.00	06900	ELECTROCARDIOLOGY	0.075333	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.202909	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.181547	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.164695	73.00
74.00	07400	RENAL DIALYSIS	0.323894	74.00
76.00	03020	ACUPUNCTURE	0.000000	76.00
76.01	03610	SLEEP LAB	0.489936	76.01
76.03	03951	WOUND CARE	2.279145	76.03
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.110060	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.493853	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	96.00
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: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet C Part I Date/Time Prepared: 8/28/2023 9:39 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,656,432		6,656,432	0	6,656,432	30.00
31.00	03100	INTENSIVE CARE UNIT	3,469,833		3,469,833	0	3,469,833	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,059,982		9,059,982	0	9,059,982	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	125,350		125,350	0	125,350	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,965,865		2,965,865	0	2,965,865	54.00
54.01	05401	ULTRASOUND	476,905		476,905	0	476,905	54.01
56.00	05600	RADIOISOTOPE	444,692		444,692	0	444,692	56.00
57.00	05700	CT SCAN	788,012		788,012	0	788,012	57.00
58.00	05800	MRI	393,319		393,319	0	393,319	58.00
60.00	06000	LABORATORY	4,331,081		4,331,081	0	4,331,081	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	223,327		223,327	0	223,327	62.00
65.00	06500	RESPIRATORY THERAPY	1,496,987	0	1,496,987	0	1,496,987	65.00
66.00	06600	PHYSICAL THERAPY	1,187,876	0	1,187,876	0	1,187,876	66.00
67.00	06700	OCCUPATIONAL THERAPY	250,158	0	250,158	0	250,158	67.00
68.00	06800	SPEECH PATHOLOGY	31,287	0	31,287	0	31,287	68.00
69.00	06900	ELECTROCARDIOLOGY	3,246,707		3,246,707	0	3,246,707	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,664,575		1,664,575	0	1,664,575	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,897,186		4,897,186	0	4,897,186	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,044,886		3,044,886	0	3,044,886	73.00
74.00	07400	RENAL DIALYSIS	232,676		232,676	0	232,676	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	401,857		401,857	0	401,857	76.01
76.03	03951	WOUND CARE	324,646		324,646	0	324,646	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,573,727		4,573,727	0	4,573,727	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	994,758		994,758		994,758	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
200.00		Subtotal (see instructions)	51,282,124	0	51,282,124	0	51,282,124	200.00
201.00		Less Observation Beds	994,758		994,758		994,758	201.00
202.00		Total (see instructions)	50,287,366	0	50,287,366	0	50,287,366	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet C Part I Date/Time Prepared: 8/28/2023 9:39 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,441,092		17,441,092			30.00
31.00	03100	INTENSIVE CARE UNIT	3,640,095		3,640,095			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,556,449	53,136,171	69,692,620	0.129999	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	3,321,863	8,553,083	11,874,946	0.010556	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,301,591	9,518,255	10,819,846	0.274113	0.000000	54.00
54.01	05401	ULTRASOUND	521,592	2,708,460	3,230,052	0.147646	0.000000	54.01
56.00	05600	RADIOISOTOPE	2,255,703	5,191,022	7,446,725	0.059716	0.000000	56.00
57.00	05700	CT SCAN	6,411,160	23,310,498	29,721,658	0.026513	0.000000	57.00
58.00	05800	MRI	322,382	5,406,591	5,728,973	0.068654	0.000000	58.00
60.00	06000	LABORATORY	16,312,394	51,351,942	67,664,336	0.064008	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	449,256	302,158	751,414	0.297209	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	7,527,770	1,373,026	8,900,796	0.168186	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,569,175	3,022,213	5,591,388	0.212447	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,392,223	552,081	1,944,304	0.128662	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	138,799	67,172	205,971	0.151900	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	24,512,980	18,585,367	43,098,347	0.075333	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,505,237	3,698,305	8,203,542	0.202909	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,156,796	14,818,017	26,974,813	0.181547	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,442,280	9,045,705	18,487,985	0.164695	0.000000	73.00
74.00	07400	RENAL DIALYSIS	662,064	56,307	718,371	0.323894	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	820,223	820,223	0.489936	0.000000	76.01
76.03	03951	WOUND CARE	5,446	136,996	142,442	2.279145	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,797,588	33,758,989	41,556,577	0.110060	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	859,714	1,154,565	2,014,279	0.493853	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
200.00		Subtotal (see instructions)	140,103,649	246,567,146	386,670,795			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	140,103,649	246,567,146	386,670,795			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet C Part I Date/Time Prepared: 8/28/2023 9:39 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
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	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
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
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
76.03	03951	WOUND CARE	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
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: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet D Part I Date/Time Prepared: 8/28/2023 9:39 am

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	918,327	0	918,327	4,403	208.57	30.00
31.00	INTENSIVE CARE UNIT	398,221		398,221	586	679.56	31.00
43.00	NURSERY	0		0	0	0.00	43.00
200.00	Total (lines 30 through 199)	1,316,548		1,316,548	4,989		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,651	344,349				30.00
31.00	INTENSIVE CARE UNIT	206	139,989				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	1,857	484,338				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet D Part II Date/Time Prepared: 8/28/2023 9:39 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	731,149	69,692,620	0.010491	5,112,258	53,633	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	12,486	11,874,946	0.001051	1,066,383	1,121	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	248,674	10,819,846	0.022983	530,865	12,201	54.00
54.01	05401	ULTRASOUND	65,365	3,230,052	0.020237	198,587	4,019	54.01
56.00	05600	RADIOISOTOPE	28,575	7,446,725	0.003837	847,973	3,254	56.00
57.00	05700	CT SCAN	54,339	29,721,658	0.001828	2,726,928	4,985	57.00
58.00	05800	MRI	42,008	5,728,973	0.007333	130,111	954	58.00
60.00	06000	LABORATORY	206,047	67,664,336	0.003045	6,737,396	20,515	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	9,056	751,414	0.012052	179,388	2,162	62.00
65.00	06500	RESPIRATORY THERAPY	59,333	8,900,796	0.006666	3,048,345	20,320	65.00
66.00	06600	PHYSICAL THERAPY	194,516	5,591,388	0.034788	1,263,307	43,948	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,647	1,944,304	0.004447	725,261	3,225	67.00
68.00	06800	SPEECH PATHOLOGY	2,898	205,971	0.014070	68,258	960	68.00
69.00	06900	ELECTROCARDIOLOGY	185,656	43,098,347	0.004308	8,493,522	36,590	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	31,463	8,203,542	0.003835	1,974,798	7,573	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	77,370	26,974,813	0.002868	3,669,454	10,524	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	94,678	18,487,985	0.005121	3,414,469	17,485	73.00
74.00	07400	RENAL DIALYSIS	11,394	718,371	0.015861	289,616	4,594	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	67,759	820,223	0.082610	0	0	76.01
76.03	03951	WOUND CARE	80,900	142,442	0.567950	3,356	1,906	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	363,108	41,556,577	0.008738	3,359,481	29,355	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	137,238	2,014,279	0.068133	405,431	27,623	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50 through 199)	2,712,659	365,589,608		44,245,187	306,947	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet D Part III Date/Time Prepared: 8/28/2023 9:39 am

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	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	4,403	0.00	1,651	30.00
31.00	03100	INTENSIVE CARE UNIT		0	586	0.00	206	31.00
43.00	04300	NURSERY		0	0	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	4,989		1,857	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: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet D Part IV Date/Time Prepared: 8/28/2023 9:39 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet D Part IV Date/Time Prepared: 8/28/2023 9:39 am

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	69,692,620	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	11,874,946	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,819,846	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	3,230,052	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	7,446,725	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	29,721,658	0.000000	57.00
58.00	05800	MRI	0	0	0	5,728,973	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	67,664,336	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	751,414	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,900,796	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,591,388	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,944,304	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	205,971	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	43,098,347	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,203,542	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	26,974,813	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	18,487,985	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	718,371	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	820,223	0.000000	76.01
76.03	03951	WOUND CARE	0	0	0	142,442	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	41,556,577	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,014,279	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
200.00		Total (lines 50 through 199)	0	0	0	365,589,608		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet D Part IV Date/Time Prepared: 8/28/2023 9:39 am

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	5,112,258	0	13,936,077	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	1,066,383	0	2,153,667	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	530,865	0	2,472,051	0	54.00
54.01	05401	ULTRASOUND	0.000000	198,587	0	600,664	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	847,973	0	1,227,244	0	56.00
57.00	05700	CT SCAN	0.000000	2,726,928	0	5,536,464	0	57.00
58.00	05800	MRI	0.000000	130,111	0	1,284,146	0	58.00
60.00	06000	LABORATORY	0.000000	6,737,396	0	3,957,657	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	179,388	0	135,133	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,048,345	0	487,718	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,263,307	0	75,319	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	725,261	0	33,089	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68,258	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	8,493,522	0	6,413,699	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,974,798	0	993,213	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,669,454	0	5,664,721	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,414,469	0	2,564,667	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	289,616	0	42,259	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	143,615	0	76.01
76.03	03951	WOUND CARE	0.000000	3,356	0	43,228	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	3,359,481	0	6,094,507	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	405,431	0	348,496	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		44,245,187	0	54,207,634	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet D Part V Date/Time Prepared: 8/28/2023 9:39 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.129999	13,936,077	0	0	1,811,676	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	0.010556	2,153,667	0	0	22,734	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.274113	2,472,051	0	0	677,621	54.00
54.01	05401	ULTRASOUND	0.147646	600,664	0	0	88,686	54.01
56.00	05600	RADIOISOTOPE	0.059716	1,227,244	0	0	73,286	56.00
57.00	05700	CT SCAN	0.026513	5,536,464	0	0	146,788	57.00
58.00	05800	MRI	0.068654	1,284,146	0	0	88,162	58.00
60.00	06000	LABORATORY	0.064008	3,957,657	0	0	253,322	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.297209	135,133	0	0	40,163	62.00
65.00	06500	RESPIRATORY THERAPY	0.168186	487,718	0	0	82,027	65.00
66.00	06600	PHYSICAL THERAPY	0.212447	75,319	0	0	16,001	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.128662	33,089	0	0	4,257	67.00
68.00	06800	SPEECH PATHOLOGY	0.151900	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.075333	6,413,699	0	0	483,163	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.202909	993,213	0	0	201,532	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.181547	5,664,721	0	0	1,028,413	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.164695	2,564,667	0	0	422,388	73.00
74.00	07400	RENAL DIALYSIS	0.323894	42,259	0	0	13,687	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.489936	143,615	0	0	70,362	76.01
76.03	03951	WOUND CARE	2.279145	43,228	0	0	98,523	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.110060	6,094,507	0	0	670,761	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.493853	348,496	0	0	172,106	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		54,207,634	0	0	6,465,658	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		54,207,634	0	0	6,465,658	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet D Part V Date/Time Prepared: 8/28/2023 9:39 am

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		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet D-1 | Date/Time Prepared: 8/28/2023 9:39 am

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)	4,403	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,403	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,745	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,651	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)	6,656,432	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)	6,656,432	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)	6,656,432	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)	1,511.79	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,495,965	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)	2,495,965	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet D-1 | Date/Time Prepared: 8/28/2023 9:39 am

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,469,833	586	5,921.22	206	1,219,771	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)	5,292,364	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)	9,008,100	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)	484,338	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	306,947	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	791,285	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	8,216,815	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)	658	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,511.79	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	994,758	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet D-1 | Date/Time Prepared: 8/28/2023 9:39 am

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	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	918,327	6,656,432	0.137961	994,758	137,238	90.00
91.00	Nursing Program cost	0	6,656,432	0.000000	994,758	0	91.00
92.00	Allied health cost	0	6,656,432	0.000000	994,758	0	92.00
93.00	All other Medical Education	0	6,656,432	0.000000	994,758	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet D-3 | Date/Time Prepared: 8/28/2023 9:39 am

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		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		7,981,584		30.00
31.00	03100	INTENSIVE CARE UNIT		1,278,770		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.129999	5,112,258	664,588	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.010556	1,066,383	11,257	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.274113	530,865	145,517	54.00
54.01	05401	ULTRASOUND	0.147646	198,587	29,321	54.01
56.00	05600	RADIOISOTOPE	0.059716	847,973	50,638	56.00
57.00	05700	CT SCAN	0.026513	2,726,928	72,299	57.00
58.00	05800	MRI	0.068654	130,111	8,933	58.00
60.00	06000	LABORATORY	0.064008	6,737,396	431,247	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.297209	179,388	53,316	62.00
65.00	06500	RESPIRATORY THERAPY	0.168186	3,048,345	512,689	65.00
66.00	06600	PHYSICAL THERAPY	0.212447	1,263,307	268,386	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.128662	725,261	93,314	67.00
68.00	06800	SPEECH PATHOLOGY	0.151900	68,258	10,368	68.00
69.00	06900	ELECTROCARDIOLOGY	0.075333	8,493,522	639,842	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.202909	1,974,798	400,704	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.181547	3,669,454	666,178	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.164695	3,414,469	562,346	73.00
74.00	07400	RENAL DIALYSIS	0.323894	289,616	93,805	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.489936	0	0	76.01
76.03	03951	WOUND CARE	2.279145	3,356	7,649	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.110060	3,359,481	369,744	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.493853	405,431	200,223	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		44,245,187	5,292,364	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		44,245,187		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0184	Period: From 05/01/2022 To 01/13/2023	Worksheet E Part A Date/Time Prepared: 8/28/2023 9:39 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,688,733	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,862,662	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)	64,725	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	15,959	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)	91.45	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	7.31	30.00
31.00	Percentage of Medicaid patient days (see instructions)	15.95	31.00
32.00	Sum of lines 30 and 31	23.26	32.00
33.00	Allowable disproportionate share percentage (see instructions)	8.40	33.00
34.00	Disproportionate share adjustment (see instructions)	95,580	34.00

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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	282,179	300,824	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	118,283	86,538	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	204,821		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00

		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	4,932,480		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)	4,932,480	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	347,946	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	36,558	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	5,316,984	59.00
60.00	Primary payer payments	5,861	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	5,311,123	61.00
62.00	Deductibles billed to program beneficiaries	585,760	62.00
63.00	Coinsurance billed to program beneficiaries	5,446	63.00
64.00	Allowable bad debts (see instructions)	200,737	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	130,479	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	152,360	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	4,850,396	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)	0	70.75
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	0	70.93
70.94	HRR adjustment amount (see instructions)	-9,345	70.94
70.95	Recovery of accelerated depreciation	0	70.95

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		4,841,051	71.00
71.01	Sequestration adjustment (see instructions)		85,687	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		4,643,886	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)		111,478	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		1,525,521	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	6,465,658	2.00
3.00	OPPS or REH payments	3,555,825	3.00
4.00	Outlier payment (see instructions)	131,514	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	3,687,339	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)	651,784	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,035,555	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	3,035,555	30.00
31.00	Primary payer payments	330	31.00
32.00	Subtotal (line 30 minus line 31)	3,035,225	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)	213,752	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	138,939	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	159,525	36.00
37.00	Subtotal (see instructions)	3,174,164	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-7	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)	3,174,171	40.00
40.01	Sequestration adjustment (see instructions)	56,183	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	3,118,095	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)	-107	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet E-1 Part I Date/Time Prepared: 8/28/2023 9:39 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,643,886		3,081,995	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	12/28/2022	36,100	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		36,100	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,643,886		3,118,095	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		111,478		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		107	6.02
7.00	Total Medicare program liability (see instructions)		4,755,364		3,117,988	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0184	Period: From 05/01/2022 To 01/13/2023	Worksheet E-1 Part II Date/Time Prepared: 8/28/2023 9:39 am
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		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: 14-0184	Period: From 05/01/2022 To 01/13/2023	Worksheet E-5 Date/Time Prepared: 8/28/2023 9:39 am
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		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: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet G | Date/Time Prepared: 8/28/2023 9:39 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-510,817	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	17,095,177	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,091,644	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	7,845,552	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)	18,338,268	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	0	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	148,174	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	148,174	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	18,486,442	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	9,868,873	0	0	0	37.00
38.00	Salaries, wages, and fees payable	486,548	0	0	0	38.00
39.00	Payroll taxes payable	-20,198	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-128,262,781	0	0	0	43.00
44.00	Other current liabilities	103,345	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-117,824,213	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-117,824,213	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	136,310,655				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)	136,310,655	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	18,486,442	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet G-1 | Date/Time Prepared: 8/28/2023 9:39 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		44,597,815		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		91,712,273				2.00
3.00	Total (sum of line 1 and line 2)		136,310,088		0		3.00
4.00	ROUNDING	567		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		567		0		10.00
11.00	Subtotal (line 3 plus line 10)		136,310,655		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		136,310,655		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	ROUNDING		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/28/2023 9:39 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	17,441,092		17,441,092	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)	17,441,092		17,441,092	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,621,332		3,621,332	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)	3,621,332		3,621,332	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	21,062,424		21,062,424	17.00
18.00	Ancillary services	110,365,160	211,653,592	322,018,752	18.00
19.00	Outpatient services	8,657,302	34,932,317	43,589,619	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	140,084,886	246,585,909	386,670,795	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		-23,468,459		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		-23,468,459		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0184 | Period: From 05/01/2022 To 01/13/2023 | Worksheet G-3 | Date/Time Prepared: 8/28/2023 9:39 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	386,670,795	1.00
2.00	Less contractual allowances and discounts on patients' accounts	318,915,606	2.00
3.00	Net patient revenues (line 1 minus line 2)	67,755,189	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	-23,468,459	4.00
5.00	Net income from service to patients (line 3 minus line 4)	91,223,648	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	78,322	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	1,736	21.00
22.00	Rental of hospital space	6,606	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	46,387	24.00
24.50	COVID-19 PHE Funding	355,574	24.50
25.00	Total other income (sum of lines 6-24)	488,625	25.00
26.00	Total (line 5 plus line 25)	91,712,273	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	91,712,273	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0184	Period: From 05/01/2022 To 01/13/2023	Worksheet L Parts I-III Date/Time Prepared: 8/28/2023 9:39 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	339,116	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	8,830	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)	16.79	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)	347,946	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