

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: 14-0011	Period: From 04/01/2022 To 03/31/2023	Worksheet S Parts I-III Date/Time Prepared: 8/30/2023 10:56 am
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 8/30/2023	Time: 10:56 am
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HERRIN HOSPITAL ( 14-0011 ) for the cost reporting period beginning 04/01/2022 and ending 03/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1			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			2
3	Signatory Title			3
4	Date			4

		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>							
1.00	HOSPITAL	0	343,566	-37,077	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	-52,296	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	291,270	-37,077	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: 14-0011		Period: From 04/01/2022 To 03/31/2023		Worksheet S-2 Part I Date/Time Prepared: 8/30/2023 10:53 am		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 201 S. 14TH STREET			PO Box:				1.00			
2.00	City: HERRIN			State: IL		Zip Code: 62948		County:			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
								V	XVIII	XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital			HERRIN HOSPITAL	140011	16060	1	07/01/1966	N	P	0
4.00	Subprovider - IPF										
5.00	Subprovider - IRF			HERRIN HOSPITAL ACUTE REHAB	14T011	16060	5	04/01/1998	N	P	0
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF										
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA										
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC										
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
18.00	Renal Dialysis										
19.00	Other										
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						04/01/2022	03/31/2023		20.00	
21.00	Type of Control (see instructions)						2			21.00	
							1.00	2.00	3.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00	
22.01	Did this hospital receive interim UCPS, including supplemental UCPS, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					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.					1	N			23.00	

## HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet S-2  
Part I  
Date/Time Prepared:  
8/30/2023 10:53 am

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	510	296	0	0	3,050	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.	49	58	0	0	349		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					1		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					04/01/2022	03/31/2023	38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					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)					Y	N	40.00
					V	XVII	XIX
					1.00	2.00	3.00
45.00 Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)					N	N	N
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
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
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
56.00 Teaching Hospitals 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		
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.							
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.							

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 14-0011		Period: From 04/01/2022 To 03/31/2023		Worksheet S-2 Part I Date/Time Prepared: 8/30/2023 10:53 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	
					1.00	2.00	3.00	
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	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	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	61.20
					1.00			
62.00	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

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From 04/01/2022  
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Part I  
Date/Time Prepared:  
8/30/2023 10:53 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			
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?			N	68.00	
			1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00	
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N N 0	76.00	
			1.00			
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00	
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00	
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments		
			1.00	2.00		
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.			0	88.00	
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
			1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.			0.00	0	89.00
			V	XIX		
			1.00	2.00		
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	97.00

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		V 1.00	XIX 2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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
<b>Rural Providers</b>				
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00
		Physical 1.00	Occupational 2.00	Speech 3.00
				Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			109.00
				1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N	110.00
				1.00
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
<b>Miscellaneous Cost Reporting Information</b>				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0011	Period: From 04/01/2022 To 03/31/2023	Worksheet S-2 Part I Date/Time Prepared: 8/30/2023 10:53 am
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	2,279,641	0	0
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	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	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
<b>Certified Transplant Center Information</b>				
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
<b>All Providers</b>				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H124	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: SOUTHERN ILLINOIS HEALTHCARE	Contractor's Name: NGS	Contractor's Number: 06101	141.00
142.00	Street: 1239 E MAIN STREET	PO Box: 3988		142.00
143.00	City: CARBONDALE	State: IL	Zip Code: 62902-3988	143.00
				1.00
144.00	Are provider based physicians' costs included in Worksheet A?	Y		144.00
		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00



HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0011		Period: From 04/01/2022 To 03/31/2023		Worksheet S-2 Part I Date/Time Prepared: 8/30/2023 10:53 am	
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N	155.00	
156.00	Subprovider - IPF			N	N	N	N	156.00	
157.00	Subprovider - IRF			N	N	N	N	157.00	
158.00	SUBPROVIDER							158.00	
159.00	SNF			N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY			N	N	N	N	160.00	
161.00	CMHC				N	N	N	161.00	
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus
				0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
							Beginning	Ending	
							1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
							1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0011		Period: From 04/01/2022 To 03/31/2023		Worksheet S-2 Part II Date/Time Prepared: 8/30/2023 10:53 am	
				Y/N	Date		
				1.00	2.00		
<b>PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE</b>							
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
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			
<b>Financial Data and Reports</b>							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y					5.00
				Y/N	Legal Oper.		
				1.00	2.00		
<b>Approved Educational Activities</b>							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
<b>Bad Debts</b>							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			Y			13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N			14.00
<b>Bed Complement</b>							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
<b>PS&amp;R Data</b>							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	08/04/2023	Y	08/04/2023		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: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet S-2  
Part II  
Date/Time Prepared:  
8/30/2023 10:53 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
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		Y		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.		Y		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LUANNE	WARREN		41.00
42.00	Enter the employer/company name of the cost report preparer.	SOUTHERN ILLINOIS HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-457-5200	LUANNE.WARREN@SIH.NET		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet S-2  
Part II  
Date/Time Prepared:  
8/30/2023 10:53 am

		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT DIRECTOR		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

HFS Supplemental Information

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet S-2  
Part IX  
Date/Time Prepared:  
8/30/2023 10:53 am

		Title V	Title XIX	
		1.00	2.00	
<b>TITLES V AND/OR XIX FOLLOWING MEDICARE</b>				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Intens and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01
3.02	Does Title XIX transfer managed care (HMO) days from Worksheet S-3, Part I, column 7, sum of lines 2, 3, and 4 to Worksheet E-4, column 2, line 26?		Y	3.02
		Inpatient	Outpatient	
		1.00	2.00	
<b>CRITICAL ACCESS HOSPITALS</b>				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
<b>RCE DISALLOWANCE</b>				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)	Y	Y	6.00
<b>PASS THROUGH COST</b>				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	Y	Y	7.00
<b>RHC</b>				
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
<b>FOHC</b>				
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00
		State		
		1.00		
<b>STATE MEDICAID FORMS</b>				
10.00	Select the state when using state Medicaid forms.			10.00

## HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet S-3  
Part I  
Date/Time Prepared:  
8/30/2023 10:53 am

Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	I/P Days / O/P	
	Line No.		Avai l a b l e		Vi s i t s / T r i p s	
	1.00	2.00	3.00	4.00	5.00	
PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	77	28,105	0.00	0
2.00	HMO and other (see instructions)					
3.00	HMO IPF Subprovider					
4.00	HMO IRF Subprovider					
5.00	Hospital Adults & Peds. Swing Bed SNF					0
6.00	Hospital Adults & Peds. Swing Bed NF					0
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		77	28,105	0.00	0
8.00	INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0
9.00	CORONARY CARE UNIT					
10.00	BURN INTENSIVE CARE UNIT					
11.00	SURGICAL INTENSIVE CARE UNIT					
12.00	OTHER SPECIAL CARE (SPECIFY)					
13.00	NURSERY					
14.00	Total (see instructions)		85	31,025	0.00	0
15.00	CAH visits					0
15.10	REH hours and visits					
16.00	SUBPROVIDER - IPF					
17.00	SUBPROVIDER - IRF	41.00	29	10,585		0
18.00	SUBPROVIDER					
19.00	SKILLED NURSING FACILITY					
20.00	NURSING FACILITY					
21.00	OTHER LONG TERM CARE					
22.00	HOME HEALTH AGENCY					
23.00	AMBULATORY SURGICAL CENTER (D.P.)					
24.00	HOSPICE					
24.10	HOSPICE (non-distinct part)	30.00				
25.00	CMHC - CMHC					
26.00	RURAL HEALTH CLINIC					
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0
27.00	Total (sum of lines 14-26)		114			
28.00	Observation Bed Days					0
29.00	Ambulance Trips					
30.00	Employee discount days (see instruction)					
31.00	Employee discount days - IRF					
32.00	Labor & delivery days (see instructions)		0	0		
32.01	Total ancillary labor & delivery room outpatient days (see instructions)					
33.00	LTCH non-covered days					
33.01	LTCH site neutral days and discharges					
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0

## HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet S-3  
Part I  
Date/Time Prepared:  
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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)	12,034	398	23,568			1.00
2.00	HMO and other (see instructions)	5,777	3,408				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	675	428				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)	12,034	398	23,568			7.00
8.00	INTENSIVE CARE UNIT	1,022	59	2,278			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)	13,056	457	25,846	0.00	712.27	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	3,511	75	5,801	0.00	43.86	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	756.13	27.00
28.00	Observation Bed Days		30	3,174			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: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet S-3  
Part I  
Date/Time Prepared:  
8/30/2023 10:53 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
<b>PART I - STATISTICAL DATA</b>						
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,300	93	4,943	1.00
2.00 HMO and other (see instructions)			986	832		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				31		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	2,300	93	4,943	14.00
15.00 CAH visits						15.00
15.10 REH hours and visits						15.10
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	273	5	414	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: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet S-3  
Part II  
Date/Time Prepared:  
8/30/2023 10:53 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 + col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	57,000,253	0	57,000,253	1,572,741.62	36.24
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		341,865	0	341,865	6,204.89	55.10
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		4,112,083	-145,000	3,967,083	94,267.12	42.08
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		13,524,791	0	13,524,791	94,799.56	142.67
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		78,837	0	78,837	466.00	169.18
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		9,738,225	0	9,738,225	238,049.52	40.91
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		8,255,145	0	8,255,145		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		621,523	0	621,523		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		53,560	0	53,560		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		3,878,797	0	3,878,797		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

## HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet S-3  
Part II  
Date/Time Prepared:  
8/30/2023 10:53 am

		Wkst. A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	146,719	0	146,719	4,167.26	35.21	26.00
27.00	Administrative & General	5.00	3,390,306	0	3,390,306	138,079.13	24.55	27.00
28.00	Administrative & General under contract (see inst.)		126,542	0	126,542	426.82	296.48	28.00
29.00	Maintenance & Repairs	6.00	649,185	0	649,185	22,052.88	29.44	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	44,538	0	44,538	2,258.54	19.72	31.00
32.00	Housekeeping	9.00	1,239,087	0	1,239,087	67,017.65	18.49	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,298,511	-787,880	510,631	24,727.75	20.65	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	787,880	787,880	38,153.80	20.65	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,042,215	0	1,042,215	16,760.24	62.18	38.00
39.00	Central Services and Supply	14.00	203,834	0	203,834	10,836.60	18.81	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	479,815	0	479,815	18,527.01	25.90	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: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet S-3  
Part III  
Date/Time Prepared:  
8/30/2023 10:53 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	56,784,930	0	56,784,930	1,566,963.55	36.24	1.00
2.00	Excluded area salaries (see instructions)	4,112,083	-145,000	3,967,083	94,267.12	42.08	2.00
3.00	Subtotal salaries (line 1 minus line 2)	52,672,847	145,000	52,817,847	1,472,696.43	35.86	3.00
4.00	Subtotal other wages & related costs (see inst.)	23,341,853	0	23,341,853	333,315.08	70.03	4.00
5.00	Subtotal wage-related costs (see inst.)	12,133,942	0	12,133,942	0.00	22.97	5.00
6.00	Total (sum of lines 3 thru 5)	88,148,642	145,000	88,293,642	1,806,011.51	48.89	6.00
7.00	Total overhead cost (see instructions)	8,620,752	0	8,620,752	343,007.68	25.13	7.00

## HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet S-3  
Part IV  
Date/Time Prepared:  
8/30/2023 10:53 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	885,318	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)	2,331,121	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	73,130	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	34,064	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	95,998	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	611,562	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	593,519	16.00
TAXES			
17.00	FICA-Employers Portion Only	4,161,117	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	63,018	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	57,985	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	23,396	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,930,228	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: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet S-3  
Part V  
Date/Time Prepared:  
8/30/2023 10:53 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	13,524,791	8,930,228	1.00
2.00	Hospital	13,524,791	8,930,228	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0011	Period: From 04/01/2022 To 03/31/2023	Worksheet S-10 Date/Time Prepared: 8/30/2023 10:53 am
				1.00
<b>Uncompensated and indigent care cost computation</b>				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.201421 1.00
<b>Medicaid (see instructions for each line)</b>				
2.00	Net revenue from Medicaid	18,817,414		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	12,685,448		5.00
6.00	Medicaid charges	174,875,652		6.00
7.00	Medicaid cost (line 1 times line 6)	35,223,629		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)	3,720,767		8.00
<b>Children's Health Insurance Program (CHIP) (see instructions for each line)</b>				
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
<b>Other state or local government indigent care program (see instructions for each line)</b>				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	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
<b>Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)</b>				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,720,767		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
<b>Uncompensated Care (see instructions for each line)</b>				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	7,924,414	173,132	8,097,546 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,596,143	173,132	1,769,275 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	1,596,143	173,132	1,769,275 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)	9,628,884		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	817,137		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,257,135		27.01
28.00	Non-Medicare bad debt expense (see instructions)	8,371,749		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,126,244		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,895,519		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,616,286		31.00

## RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023

Worksheet A

Date/Time Prepared:  
8/30/2023 10:53 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	4,967,064	4,967,064	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	3,257,006	3,257,006	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	146,719	71,870	218,589	13,877,518	4.00
5.01	00550	DATA PROCESSING	0	0	0	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	232,613	88,632	321,245	-80,378	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,123,959	362,417	1,486,376	-327,660	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	2,033,734	16,541,128	18,574,862	-5,267,990	5.04
6.00	00600	MAINTENANCE & REPAIRS	649,185	1,831,340	2,480,525	-298,051	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	44,538	803,825	848,363	-6,163	8.00
9.00	00900	HOUSEKEEPING	1,239,087	707,200	1,946,287	-346,626	9.00
10.00	01000	DIETARY	1,298,511	1,289,169	2,587,680	-1,701,262	10.00
11.00	01100	CAFETERIA	0	0	0	1,367,703	11.00
13.00	01300	NURSING ADMINISTRATION	1,042,215	384,998	1,427,213	-341,136	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	203,834	261,513	465,347	-200,470	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	479,815	99,220	579,035	-93,948	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	2,819,179	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	12,106,851	20,189,584	32,296,435	-2,740,817	30.00
31.00	03100	INTENSIVE CARE UNIT	2,014,171	1,636,348	3,650,519	-659,706	31.00
41.00	04100	SUBPROVIDER - IRF	3,928,598	1,787,653	5,716,251	-1,013,770	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	4,283,869	17,646,643	21,930,512	-11,458,251	50.00
51.00	05100	RECOVERY ROOM	712,325	348,239	1,060,564	-182,864	51.00
53.00	05300	ANESTHESIOLOGY	792,015	5,191,317	5,983,332	-3,061,955	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,168,459	1,450,578	3,619,037	-878,287	54.00
56.00	05600	RADIOISOTOPE	169,708	721,766	891,474	-23,908	56.00
57.00	05700	CT SCAN	651,529	916,326	1,567,855	-216,697	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	425,054	902,316	1,327,370	-621,878	58.00
60.00	06000	LABORATORY	2,386,033	6,518,340	8,904,373	-656,277	60.00
65.00	06500	RESPIRATORY THERAPY	1,203,674	1,671,133	2,874,807	-490,164	65.00
66.00	06600	PHYSICAL THERAPY	8,517,679	2,526,081	11,043,760	-2,336,709	66.00
69.00	06900	ELECTROCARDIOLOGY	1,669,159	1,402,376	3,071,535	-937,868	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,986,395	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,722,967	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,891,225	7,299,852	10,191,077	-236,260	73.00
76.97	07697	CARDIAC REHABILITATION	391,417	168,354	559,771	-156,099	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	365,864	156,325	522,189	-104,263	90.00
91.00	09100	EMERGENCY	3,644,928	7,268,068	10,912,996	-896,673	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE		0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,816,768	100,242,611	157,059,379	661,702	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	956,450	956,450	-327,054	192.00
192.01	19201	OUTREACH LAB	145,000	176,955	321,955	-321,955	192.01
192.02	19202	THERAPY CASH BASED SERVICES	38,485	13,046	51,531	-12,693	192.02
192.03	19203	VACANT SPACE	0	0	0	0	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	57,000,253	101,389,062	158,389,315	0	200.00

## RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023

Worksheet A

Date/Time Prepared:  
8/30/2023 10:53 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	-193,717	4,773,347	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,069,291	5,326,297	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	506,934	14,603,041	4.00
5.01	00550	DATA PROCESSING	8,870,547	8,870,547	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-12,912	227,955	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,220,643	3,379,359	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	1,410,963	14,717,835	5.04
6.00	00600	MAINTENANCE & REPAIRS	-35,037	2,147,437	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	842,200	8.00
9.00	00900	HOUSEKEEPING	0	1,599,661	9.00
10.00	01000	DIETARY	0	886,418	10.00
11.00	01100	CAFETERIA	-506,640	861,063	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,086,077	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	264,877	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-46,147	438,940	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-2,819,179	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-5,813,323	23,742,295	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,990,813	31.00
41.00	04100	SUBPROVIDER - IIRF	-831,872	3,870,609	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-17,280	10,454,981	50.00
51.00	05100	RECOVERY ROOM	0	877,700	51.00
53.00	05300	ANESTHESIOLOGY	0	2,921,377	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-62,903	2,677,847	54.00
56.00	05600	RADIOISOTOPE	0	867,566	56.00
57.00	05700	CT SCAN	0	1,351,158	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	705,492	58.00
60.00	06000	LABORATORY	-288,134	7,959,962	60.00
65.00	06500	RESPIRATORY THERAPY	-4,175	2,380,468	65.00
66.00	06600	PHYSICAL THERAPY	-105,337	8,601,714	66.00
69.00	06900	ELECTROCARDIOLOGY	-95,247	2,038,420	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,986,395	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,722,967	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,954,817	73.00
76.97	07697	CARDIAC REHABILITATION	-456	403,216	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-2,157	415,769	90.00
91.00	09100	EMERGENCY	-3,454,462	6,561,861	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	789,400	158,510,481	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-166,026	463,370	192.00
192.01	19201	OUTREACH LAB	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	-32,205	6,633	192.02
192.03	19203	VACANT SPACE	0	0	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	591,169	158,980,484	200.00



## COST CENTERS USED IN COST REPORT

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023

Worksheet Non-CMS W

Date/Time Prepared:  
8/30/2023 10:53 am

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01	DATA PROCESSING	00550	DATA PROCESSING	5.01
5.02	PURCHASING RECEIVING AND STORES	00560	PURCHASING RECEIVING AND STORES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	00590		5.04
6.00	MAINTENANCE & REPAIRS	00600		6.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
41.00	SUBPROVIDER - IRF	04100		41.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
56.00	RADIOISOTOPE	05600		56.00
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.97	CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
77.00	ALLOGENEIC HSCT ACQUISITION	07700		77.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
OTHER REIMBURSABLE COST CENTERS				
102.00	OPIOID TREATMENT PROGRAM	10200		102.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01	OUTREACH LAB	19201		192.01
192.02	THERAPY CASH BASED SERVICES	19202		192.02
192.03	VACANT SPACE	19203		192.03
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

## RECLASSIFICATIONS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023

Worksheet A-6

Date/Time Prepared:  
8/30/2023 10:53 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - Cafeteria					
1.00	CAFETERIA	11.00	787,880	782,212		1.00
	TOTALS		787,880	782,212		
	B - Medical Supplies					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		2,986,395		1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00						14.00
15.00						15.00
16.00			0	2,986,395		16.00
	C - CRNA					
1.00	NONPHYSICIAN ANESTHETISTS	19.00		2,819,179		1.00
			0	2,819,179		
	D - Interest					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	682,370		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	224,554		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	906,924		
	E - Contrast Drug					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	461,767		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
5.00		0.00	0	0		5.00
	TOTALS		0	461,767		
	F - Reference Lab					
1.00	LABORATORY	60.00	145,000	176,955		1.00
			145,000	176,955		
	G - Depreciation Expense					
1.00	CAP REL COSTS-BLDG & FIXT	1.00		4,284,694		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00		3,032,452		2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00						14.00
15.00						15.00
16.00						16.00
17.00						17.00
18.00						18.00
19.00						19.00
20.00						20.00
21.00						21.00
22.00						22.00
23.00						23.00
24.00						24.00
25.00						25.00
26.00						26.00
27.00						27.00
28.00						28.00
29.00						29.00
30.00			0	7,317,146		30.00

## RECLASSIFICATIONS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023

Worksheet A-6

Date/Time Prepared:  
8/30/2023 10:53 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	H - Employee Benefits					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	13,879,894	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	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
29.00		0.00	0	0	29.00	
30.00		0.00	0	0	30.00	
	TOTALS		0	13,879,894		
	I - Implantable Device					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	6,722,967	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	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
	TOTALS		0	6,722,967		
500.00	Grand Total: Increases		932,880	36,053,439	500.00	

## RECLASSIFICATIONS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023

Worksheet A-6

Date/Time Prepared:  
8/30/2023 10:53 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - Cafeteria						
1.00	DIETARY	10.00	787,880	782,212	0		1.00
	TOTALS		787,880	782,212			
	B - Medical Supplies						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04		177			1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00		2,002			2.00
3.00	ADULTS & PEDIATRICS	30.00		49,237			3.00
4.00	INTENSIVE CARE UNIT	31.00		34,485			4.00
5.00	SUBPROVIDER - IRF	41.00		5,802			5.00
6.00	OPERATING ROOM	50.00		2,656,258			6.00
7.00	ANESTHESIOLOGY	53.00		50,030			7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00		4,217			8.00
9.00	LABORATORY	60.00		26,848			9.00
10.00	RESPIRATORY THERAPY	65.00		124,296			10.00
11.00	PHYSICAL THERAPY	66.00		851			11.00
12.00	ELECTROCARDIOLOGY	69.00		185			12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00		294			13.00
14.00	CARDIAC REHABILITATION	76.97		282			14.00
15.00	CLINIC	90.00		21			15.00
16.00	EMERGENCY	91.00		31,410			16.00
			0	2,986,395			
	C - CRNA						
1.00	ANESTHESIOLOGY	53.00		2,819,179			1.00
			0	2,819,179			
	D - Interest						
1.00		0.00	0	0	11		1.00
2.00		0.00	0	0	11		2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	906,924	0		3.00
	TOTALS		0	906,924			
	E - Contrast Drug						
1.00	OPERATING ROOM	50.00	0	17,594	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	38,503	0		2.00
3.00	CT SCAN	57.00	0	8,118	0		3.00
4.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	91,823	0		4.00
5.00	ELECTROCARDIOLOGY	69.00	0	305,729	0		5.00
	TOTALS		0	461,767			
	F - Reference Lab						
1.00	OUTREACH LAB	192.01	145,000	176,955			1.00
			145,000	176,955			
	G - Depreciation Expense						
1.00					9		1.00
2.00					9		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		2,376			3.00
4.00	CASHIERING/ACCOUNTS RECEIVABLE	5.03		652			4.00
5.00	OTHER ADMINISTRATIVE AND GENERAL	5.04		3,855,345			5.00
6.00	MAINTENANCE & REPAIRS	6.00		34,534			6.00
7.00	LAUNDRY & LINEN SERVICE	8.00		316			7.00
8.00	HOUSEKEEPING	9.00		5,674			8.00
9.00	DIETARY	10.00		3,968			9.00
10.00	CAFETERIA	11.00		6,122			10.00
11.00	NURSING ADMINISTRATION	13.00		138,661			11.00
12.00	CENTRAL SERVICES & SUPPLY	14.00		96,214			12.00
13.00	ADULTS & PEDIATRICS	30.00		175,244			13.00
14.00	INTENSIVE CARE UNIT	31.00		155,660			14.00
15.00	SUBPROVIDER - IRF	41.00		56,944			15.00
16.00	OPERATING ROOM	50.00		994,137			16.00
17.00	ANESTHESIOLOGY	53.00		17,584			17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00		287,062			18.00
19.00	RADIOISOTOPE	56.00		346			19.00
20.00	CT SCAN	57.00		9,471			20.00
21.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00		393,595			21.00
22.00	LABORATORY	60.00		223,307			22.00
23.00	RESPIRATORY THERAPY	65.00		83,666			23.00
24.00	PHYSICAL THERAPY	66.00		46,312			24.00
25.00	ELECTROCARDIOLOGY	69.00		196,684			25.00
26.00	DRUGS CHARGED TO PATIENTS	73.00		87,152			26.00
27.00	CARDIAC REHABILITATION	76.97		27,058			27.00
28.00	CLINIC	90.00		16,868			28.00

## RECLASSIFICATIONS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023

Worksheet A-6

Date/Time Prepared:  
8/30/2023 10:53 am

Decreases						Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
29.00	EMERGENCY	91.00		75,140			29.00
30.00	PHYSICIANS' PRIVATE OFFICES	192.00		327,054			30.00
			0	7,317,146			
H - Employee Benefits							
1.00	PURCHASING RECEIVING AND STORES	5.02	0	80,378	0		1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.03	0	327,008	0		2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	505,544	0		3.00
4.00	MAINTENANCE & REPAIRS	6.00	0	263,517	0		4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	0	5,847	0		5.00
6.00	HOUSEKEEPING	9.00	0	340,952	0		6.00
7.00	DIETARY	10.00	0	127,202	0		7.00
8.00	CAFETERIA	11.00	0	196,267	0		8.00
9.00	NURSING ADMINISTRATION	13.00	0	202,475	0		9.00
10.00	CENTRAL SERVICES & SUPPLY	14.00	0	102,254	0		10.00
11.00	MEDICAL RECORDS & LIBRARY	16.00	0	93,948	0		11.00
12.00	ADULTS & PEDIATRICS	30.00	0	2,511,399	0		12.00
13.00	INTENSIVE CARE UNIT	31.00	0	458,834	0		13.00
14.00	SUBPROVIDER - IRF	41.00	0	949,790	0		14.00
15.00	OPERATING ROOM	50.00	0	1,097,592	0		15.00
16.00	RECOVERY ROOM	51.00	0	182,864	0		16.00
17.00	ANESTHESIOLOGY	53.00	0	175,162	0		17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	0	541,460	0		18.00
19.00	RADIOISOTOPE	56.00	0	23,562	0		19.00
20.00	CT SCAN	57.00	0	199,108	0		20.00
21.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	136,460	0		21.00
22.00	LABORATORY	60.00	0	728,077	0		22.00
23.00	RESPIRATORY THERAPY	65.00	0	282,202	0		23.00
24.00	PHYSICAL THERAPY	66.00	0	2,289,546	0		24.00
25.00	ELECTROCARDIOLOGY	69.00	0	430,425	0		25.00
26.00	DRUGS CHARGED TO PATIENTS	73.00	0	610,581	0		26.00
27.00	CARDIAC REHABILITATION	76.97	0	128,759	0		27.00
28.00	CLINIC	90.00	0	87,374	0		28.00
29.00	EMERGENCY	91.00	0	788,614	0		29.00
30.00	THERAPY CASH BASED SERVICES	192.02	0	12,693	0		30.00
	TOTALS		0	13,879,894			
I - Implantable Device							
1.00	ADULTS & PEDIATRICS	30.00	0	4,937	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	10,727	0		2.00
3.00	SUBPROVIDER - IRF	41.00	0	1,234	0		3.00
4.00	OPERATING ROOM	50.00	0	6,692,670	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	7,045	0		5.00
6.00	ELECTROCARDIOLOGY	69.00	0	4,845	0		6.00
7.00	EMERGENCY	91.00	0	1,509	0		7.00
	TOTALS		0	6,722,967			
500.00	Grand Total: Decreases		932,880	36,053,439			500.00

## RECLASSIFICATIONS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet A-6  
Non-CMS Worksheet  
Date/Time Prepared:  
8/30/2023 10:53 am

Increases					Decreases				
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
A - Cafeteria									
1.00	CAFETERIA	11.00	787,880	782,212	DIETARY	10.00	787,880	782,212	1.00
	TOTALS		787,880	782,212	TOTALS		787,880	782,212	
B - Medical Supplies									
1.00	MEDICAL SUPPLIES	71.00		2,986,395	OTHER ADMINISTRATIVE	5.04		177	1.00
2.00	CHARGED TO PATIENTS				AND GENERAL				
					CENTRAL SERVICES &	14.00		2,002	2.00
					SUPPLY				
3.00					ADULTS & PEDIATRICS	30.00		49,237	3.00
4.00					INTENSIVE CARE UNIT	31.00		34,485	4.00
5.00					SUBPROVIDER - IRF	41.00		5,802	5.00
6.00					OPERATING ROOM	50.00		2,656,258	6.00
7.00					ANESTHESIOLOGY	53.00		50,030	7.00
8.00					RADIOLOGY-DIAGNOSTIC	54.00		4,217	8.00
9.00					LABORATORY	60.00		26,848	9.00
10.00					RESPIRATORY THERAPY	65.00		124,296	10.00
11.00					PHYSICAL THERAPY	66.00		851	11.00
12.00					ELECTROCARDIOLOGY	69.00		185	12.00
13.00					DRUGS CHARGED TO	73.00		294	13.00
					PATIENTS				
14.00					CARDIAC	76.97		282	14.00
					REHABILITATION				
15.00					CLINIC	90.00		21	15.00
16.00					EMERGENCY	91.00		31,410	16.00
			0	2,986,395			0	2,986,395	
C - CRNA									
1.00	NONPHYSICIAN	19.00		2,819,179	ANESTHESIOLOGY	53.00		2,819,179	1.00
	ANESTHETISTS								
			0	2,819,179			0	2,819,179	
D - Interest									
1.00	CAP REL COSTS-BLDG &	1.00	0	682,370		0.00	0	0	1.00
	FIXT								
2.00	CAP REL COSTS-MVBLE	2.00	0	224,554		0.00	0	0	2.00
	EQUIP								
3.00		0.00	0	0	OTHER ADMINISTRATIVE	5.04	0	906,924	3.00
					AND GENERAL				
	TOTALS		0	906,924	TOTALS		0	906,924	
E - Contrast Drug									
1.00	DRUGS CHARGED TO	73.00	0	461,767	OPERATING ROOM	50.00	0	17,594	1.00
	PATIENTS								
2.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	38,503	2.00
3.00		0.00	0	0	OCT SCAN	57.00	0	8,118	3.00
4.00		0.00	0	0	MAGNETIC RESONANCE	58.00	0	91,823	4.00
					IMAGING (MRI)				
5.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	305,729	5.00
	TOTALS		0	461,767	TOTALS		0	461,767	
F - Reference Lab									
1.00	LABORATORY	60.00	145,000	176,955	OUTREACH LAB	192.01	145,000	176,955	1.00
			145,000	176,955			145,000	176,955	
G - Depreciation Expense									
1.00	CAP REL COSTS-BLDG &	1.00		4,284,694					1.00
	FIXT								
2.00	CAP REL COSTS-MVBLE	2.00		3,032,452					2.00
	EQUIP								
3.00					EMPLOYEE BENEFITS	4.00		2,376	3.00
					DEPARTMENT				
4.00					CASHIERING/ACCOUNTS	5.03		652	4.00
					RECEIVABLE				
5.00					OTHER ADMINISTRATIVE	5.04		3,855,345	5.00
					AND GENERAL				
6.00					MAINTENANCE & REPAIRS	6.00		34,534	6.00
7.00					LAUNDRY & LINEN	8.00		316	7.00
					SERVICE				
8.00					HOUSEKEEPING	9.00		5,674	8.00
9.00					DIETARY	10.00		3,968	9.00
10.00					CAFETERIA	11.00		6,122	10.00
11.00					NURSING	13.00		138,661	11.00
					ADMINISTRATION				
12.00					CENTRAL SERVICES &	14.00		96,214	12.00
					SUPPLY				
13.00					ADULTS & PEDIATRICS	30.00		175,244	13.00
14.00					INTENSIVE CARE UNIT	31.00		155,660	14.00
15.00					SUBPROVIDER - IRF	41.00		56,944	15.00
16.00					OPERATING ROOM	50.00		994,137	16.00
17.00					ANESTHESIOLOGY	53.00		17,584	17.00

## RECLASSIFICATIONS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet A-6  
Non-CMS Worksheet  
Date/Time Prepared:  
8/30/2023 10:53 am

Increases					Decreases				
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
18.00					RADIOLOGY-DIAGNOSTIC	54.00		287,062	18.00
19.00					RADIOISOTOPE	56.00		346	19.00
20.00					CT SCAN	57.00		9,471	20.00
21.00					MAGNETIC RESONANCE	58.00		393,595	21.00
22.00					IMAGING (MRI)				
22.00					LABORATORY	60.00		223,307	22.00
23.00					RESPIRATORY THERAPY	65.00		83,666	23.00
24.00					PHYSICAL THERAPY	66.00		46,312	24.00
25.00					ELECTROCARDIOLOGY	69.00		196,684	25.00
26.00					DRUGS CHARGED TO	73.00		87,152	26.00
					PATIENTS				
27.00					CARDIAC	76.97		27,058	27.00
					REHABILITATION				
28.00					CLINIC	90.00		16,868	28.00
29.00					EMERGENCY	91.00		75,140	29.00
30.00					PHYSICIANS' PRIVATE	192.00		327,054	30.00
					OFFICES				
			0	7,317,146			0	7,317,146	
H - Employee Benefits									
1.00	EMPLOYEE BENEFITS	4.00	0	13,879,894	PURCHASING RECEIVING	5.02	0	80,378	1.00
	DEPARTMENT				AND STORES				
2.00		0.00	0		CASHIERING/ACCOUNTS	5.03	0	327,008	2.00
					RECEIVABLE				
3.00		0.00	0		OTHER ADMINISTRATIVE	5.04	0	505,544	3.00
					AND GENERAL				
4.00		0.00	0		MAINTENANCE & REPAIRS	6.00	0	263,517	4.00
5.00		0.00	0		LAUNDRY & LINEN	8.00	0	5,847	5.00
					SERVICE				
6.00		0.00	0		HOUSEKEEPING	9.00	0	340,952	6.00
7.00		0.00	0		DIETARY	10.00	0	127,202	7.00
8.00		0.00	0		CAFETERIA	11.00	0	196,267	8.00
9.00		0.00	0		NURSING	13.00	0	202,475	9.00
					ADMINISTRATION				
10.00		0.00	0		CENTRAL SERVICES &	14.00	0	102,254	10.00
					SUPPLY				
11.00		0.00	0		MEDICAL RECORDS &	16.00	0	93,948	11.00
					LIBRARY				
12.00		0.00	0		ADULTS & PEDIATRICS	30.00	0	2,511,399	12.00
13.00		0.00	0		INTENSIVE CARE UNIT	31.00	0	458,834	13.00
14.00		0.00	0		SUBPROVIDER - IIRF	41.00	0	949,790	14.00
15.00		0.00	0		OPERATING ROOM	50.00	0	1,097,592	15.00
16.00		0.00	0		RECOVERY ROOM	51.00	0	182,864	16.00
17.00		0.00	0		ANESTHESIOLOGY	53.00	0	175,162	17.00
18.00		0.00	0		RADIOLOGY-DIAGNOSTIC	54.00	0	541,460	18.00
19.00		0.00	0		RADIOISOTOPE	56.00	0	23,562	19.00
20.00		0.00	0		CT SCAN	57.00	0	199,108	20.00
21.00		0.00	0		MAGNETIC RESONANCE	58.00	0	136,460	21.00
					IMAGING (MRI)				
22.00		0.00	0		LABORATORY	60.00	0	728,077	22.00
23.00		0.00	0		RESPIRATORY THERAPY	65.00	0	282,202	23.00
24.00		0.00	0		PHYSICAL THERAPY	66.00	0	2,289,546	24.00
25.00		0.00	0		ELECTROCARDIOLOGY	69.00	0	430,425	25.00
26.00		0.00	0		DRUGS CHARGED TO	73.00	0	610,581	26.00
					PATIENTS				
27.00		0.00	0		CARDIAC	76.97	0	128,759	27.00
					REHABILITATION				
28.00		0.00	0		CLINIC	90.00	0	87,374	28.00
29.00		0.00	0		EMERGENCY	91.00	0	788,614	29.00
30.00		0.00	0		THERAPY CASH BASED	192.02	0	12,693	30.00
					SERVICES				
	TOTALS		0	13,879,894	TOTALS		0	13,879,894	
I - Implantable Device									
1.00	IMPL. DEV. CHARGED TO	72.00	0	6,722,967	ADULTS & PEDIATRICS	30.00	0	4,937	1.00
	PATIENTS								
2.00		0.00	0		INTENSIVE CARE UNIT	31.00	0	10,727	2.00
3.00		0.00	0		SUBPROVIDER - IIRF	41.00	0	1,234	3.00
4.00		0.00	0		OPERATING ROOM	50.00	0	6,692,670	4.00
5.00		0.00	0		RADIOLOGY-DIAGNOSTIC	54.00	0	7,045	5.00
6.00		0.00	0		ELECTROCARDIOLOGY	69.00	0	4,845	6.00
7.00		0.00	0		EMERGENCY	91.00	0	1,509	7.00
	TOTALS		0	6,722,967	TOTALS		0	6,722,967	
500.00	Grand Total:		932,880	36,053,439	Grand Total:		932,880	36,053,439	500.00
	Increases				Decreases				

## RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet A-7  
Part I  
Date/Time Prepared:  
8/30/2023 10:53 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	5,313,016	190,000	0	190,000	0	1.00
2.00	Land Improvements	5,926,671	384,108	0	384,108	11,540	2.00
3.00	Buildings and Fixtures	101,364,519	2,826,416	0	2,826,416	1,031,040	3.00
4.00	Building Improvements	35,549	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	40,829,932	902,595	0	902,595	909,344	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	153,469,687	4,303,119	0	4,303,119	1,951,924	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	153,469,687	4,303,119	0	4,303,119	1,951,924	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	5,503,016	0				1.00
2.00	Land Improvements	6,299,239	0				2.00
3.00	Buildings and Fixtures	103,159,895	0				3.00
4.00	Building Improvements	35,549	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	40,823,183	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	155,820,882	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	155,820,882	0				10.00



## RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet A-7  
Part II  
Date/Time Prepared:  
8/30/2023 10:53 am

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

## RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet A-7  
Part III  
Date/Time Prepared:  
8/30/2023 10:53 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	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	114,997,699	0	114,997,699	0.738012	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	40,823,183	0	40,823,183	0.261988	0	2.00
3.00	Total (sum of lines 1-2)	155,820,882	0	155,820,882	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital -Related Costs	Total (sum of col.s. 5 through 7)	Depreciation	Lease	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,090,977	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	5,101,743	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	9,192,720	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital -Related Costs (see instructions)	Total (2) (sum of col.s. 9 through 14)	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	682,370	0	0	0	4,773,347	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	224,554	0	0	0	5,326,297	2.00
3.00	Total (sum of lines 1-2)	906,924	0	0	0	10,099,644	3.00

## ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023

Worksheet A-8

Date/Time Prepared:  
8/30/2023 10:53 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-10,385,564			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	27,450,067			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-506,640	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	-46,147	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL 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			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-2,819,179	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	0.00	0	32.00
33.00	Leasehold Revenue	B	-564,613	CAP REL COSTS-BLDG & FIXT	1.00	9	33.00

## ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023

Worksheet A-8

Date/Time Prepared:  
8/30/2023 10:53 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	Purchase Discounts	B	-12,912	PURCHASING RECEIVING AND STORES	5.02	0	33.01
33.02	Interest Income Unrestricted	B	-199,976	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.02
33.06	Cash Based PT Services	B	-32,205	THERAPY CASH BASED SERVICES	192.02	0	33.06
34.00	Non Allowable Bonds	A	-725,382	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	34.00
35.00	Debt Forgiveness	A	-6,500	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	35.00
36.00	Cable TV	A	-35,037	MAINTENANCE & REPAIRS	6.00	0	36.00
36.01	Cable TV	A	-778	SUBPROVIDER - I RF	41.00	0	36.01
36.02	Cable TV	A	-814	PHYSICAL THERAPY	66.00	0	36.02
36.03	Cable TV	A	-1,042	CLINIC	90.00	0	36.03
36.04	Cable TV	A	-994	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	36.04
37.00	Real Estate Taxes	A	-54,311	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	37.00
37.01	Real Estate Taxes	A	-9,683	PHYSICAL THERAPY	66.00	0	37.01
37.02	Real Estate Taxes	A	-166,026	PHYSICIANS' PRIVATE OFFICES	192.00	0	37.02
38.00	Lobbying	A	-29,679	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	38.00
39.00	Medicaid Provider Tax	A	-6,275,920	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	39.00
40.00	Payments for Employee OP Services	B	-4,985,496	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		591,169				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: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023

Worksheet A-8-1

Date/Time Prepared:  
8/30/2023 10:53 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		1.00	CAP REL COSTS-BLDG & FIXT	Home Office	370,896	0 1.00
2.00		2.00	CAP REL COSTS-MVBLE EQUIP	Home Office	2,069,291	0 2.00
3.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	Home Office	5,492,430	0 3.00
4.00		5.01	DATA PROCESSING	Home Office	8,870,547	0 4.00
4.01		5.03	CASHIERING/ACCOUNTS RECEIVAB	Home Office	2,220,643	0 4.01
4.02		5.04	OTHER ADMINISTRATIVE AND GEN	Home Office	8,713,680	0 4.02
4.03		60.00	LABORATORY	Rent	35,194	69,624 4.03
4.04		54.00	RADIOLOGY-DIAGNOSTIC	Rent	54,997	117,900 4.04
4.05		66.00	PHYSICAL THERAPY	Rent	77,662	172,502 4.05
4.06		69.00	ELECTROCARDIOLOGY	Rent	62,577	157,824 4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				27,967,917	517,850 5.00

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

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

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

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

6.00	B	SIMS	100.00	SIMS	100.00	6.00
7.00	B	SIHE	100.00	SIHE	100.00	7.00
8.00	B	SIHS	100.00	SIHS	100.00	8.00
9.00	B	HSSI	100.00	HSSI	100.00	9.00
10.00	B	SIH CAYMAN	100.00	SIH CAYMAN	100.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023

Worksheet A-8-1

Date/Time Prepared:  
8/30/2023 10:53 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	370,896	9		1.00
2.00	2,069,291	9		2.00
3.00	5,492,430	0		3.00
4.00	8,870,547	0		4.00
4.01	2,220,643	0		4.01
4.02	8,713,680	0		4.02
4.03	-34,430	0		4.03
4.04	-62,903	0		4.04
4.05	-94,840	0		4.05
4.06	-95,247	0		4.06
5.00	27,450,067			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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HEALTHCARE		6.00
7.00	HEALTHCARE		7.00
8.00	HEALTHCARE		8.00
9.00	HEALTHCARE		9.00
10.00	CAPTIVE		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: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023

Worksheet A-8-2

Date/Time Prepared:  
8/30/2023 10:53 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	9,955	9,955	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	5,484,823	5,484,823	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	842,109	822,909	19,200	179,000	128	3.00
4.00	50.00	OPERATING ROOM	49,620	1,080	48,540	246,400	273	4.00
5.00	60.00	LABORATORY	253,704	253,704	0	260,300	0	5.00
6.00	65.00	RESPIRATORY THERAPY	7,962	0	7,962	179,000	44	6.00
7.00	76.97	CARDIAC REHABILITATION	800	0	800	179,000	4	7.00
8.00	90.00	CLINIC	2,578	243	2,335	179,000	17	8.00
9.00	91.00	EMERGENCY	3,454,462	3,454,462	0	181,300	0	9.00
10.00	30.00	ADULTS & PEDIATRICS	328,500	328,500	0	179,000	0	10.00
200.00			10,434,513	10,355,676	78,837		466	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	11,015	551	0	0	0	3.00
4.00	50.00	OPERATING ROOM	32,340	1,617	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	3,787	189	0	0	0	6.00
7.00	76.97	CARDIAC REHABILITATION	344	17	0	0	0	7.00
8.00	90.00	CLINIC	1,463	73	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	10.00
200.00			48,949	2,447	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	9,955		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	5,484,823		2.00
3.00	41.00	SUBPROVIDER - IRF	0	11,015	8,185	831,094		3.00
4.00	50.00	OPERATING ROOM	0	32,340	16,200	17,280		4.00
5.00	60.00	LABORATORY	0	0	0	253,704		5.00
6.00	65.00	RESPIRATORY THERAPY	0	3,787	4,175	4,175		6.00
7.00	76.97	CARDIAC REHABILITATION	0	344	456	456		7.00
8.00	90.00	CLINIC	0	1,463	872	1,115		8.00
9.00	91.00	EMERGENCY	0	0	0	3,454,462		9.00
10.00	30.00	ADULTS & PEDIATRICS	0	0	0	328,500		10.00
200.00			0	48,949	29,888	10,385,564		200.00

## COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet B  
Part I  
Date/Time Prepared:  
8/30/2023 10:53 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,773,347	4,773,347			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,326,297		5,326,297		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,603,041	34,518	4,207	14,641,766	4.00
5.01	00550	DATA PROCESSING	8,870,547	21,722	0	0	8,892,269
5.02	00560	PURCHASING RECEIVING AND STORES	227,955	39,467	0	59,906	115,348
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,379,359	35,470	1,154	289,459	367,016
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	14,717,835	877,750	0	523,758	408,960
6.00	00600	MAINTENANCE & REPAIRS	2,147,437	599,495	3,410	167,188	167,779
8.00	00800	LAUNDRY & LINEN SERVICE	842,200	0	560	11,470	10,486
9.00	00900	HOUSEKEEPING	1,599,661	57,509	10,046	319,108	31,458
10.00	01000	DIETARY	886,418	79,759	6,967	131,505	83,889
11.00	01100	CAFETERIA	861,063	87,585	10,747	202,907	0
13.00	01300	NURSING ADMINISTRATION	1,086,077	29,167	245,511	268,407	52,431
14.00	01400	CENTRAL SERVICES & SUPPLY	264,877	61,570	170,355	52,494	10,486
16.00	01600	MEDICAL RECORDS & LIBRARY	438,940	0	0	123,569	209,723
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	23,742,295	795,583	309,885	3,117,927	1,583,414
31.00	03100	INTENSIVE CARE UNIT	2,990,813	93,126	275,609	518,720	188,751
41.00	04100	SUBPROVIDER - IRF	3,870,609	365,314	99,650	1,011,751	912,296
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,454,981	587,248	1,760,201	1,103,246	1,111,534
51.00	05100	RECOVERY ROOM	877,700	88,854	0	183,449	136,320
53.00	05300	ANESTHESIOLOGY	2,921,377	592	31,134	203,972	10,486
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,677,847	144,438	507,059	558,454	304,099
56.00	05600	RADIOISOTOPE	867,566	30,394	613	43,706	31,458
57.00	05700	CT SCAN	1,351,158	37,077	16,769	167,792	10,486
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	705,492	40,821	545,263	109,466	31,458
60.00	06000	LABORATORY	7,959,962	119,247	395,259	651,830	471,877
65.00	06500	RESPIRATORY THERAPY	2,380,468	53,702	148,138	309,988	230,696
66.00	06600	PHYSICAL THERAPY	8,601,714	12,542	60,626	2,193,600	1,237,368
69.00	06900	ELECTROCARDIOLOGY	2,038,420	57,234	348,245	429,867	304,099
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,986,395	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,722,967	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	9,954,817	40,081	154,310	744,592	178,265
76.97	07697	CARDIAC REHABILITATION	403,216	135,682	47,908	100,804	94,375
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	415,769	0	29,866	94,223	136,320
91.00	09100	EMERGENCY	6,561,861	189,489	133,042	938,697	461,391
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	158,510,481	4,715,436	5,316,534	14,631,855	8,892,269
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,190	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	463,370	0	9,763	0	0
192.01	19201	OUTREACH LAB	0	0	0	0	0
192.02	19202	THERAPY CASH BASED SERVICES	6,633	0	0	9,911	0
192.03	19203	VACANT SPACE	0	39,721	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	158,980,484	4,773,347	5,326,297	14,641,766	8,892,269



## COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet B  
Part I  
Date/Time Prepared:  
8/30/2023 10:53 am

Cost Center Description			PURCHASING RECEIVING AND STORES	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
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
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	442,676					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,002	4,073,460				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	509	0	16,528,812	16,528,812		5.04
6.00	00600	MAINTENANCE & REPAIRS	3	0	3,085,312	357,992	3,443,304	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	864,716	100,334	0	8.00
9.00	00900	HOUSEKEEPING	6	0	2,017,788	234,126	62,567	9.00
10.00	01000	DIETARY	15	0	1,188,553	137,909	86,775	10.00
11.00	01100	CAFETERIA	23	0	1,162,325	134,866	95,289	11.00
13.00	01300	NURSING ADMINISTRATION	0	3	1,681,596	195,117	31,732	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	559,782	64,952	66,985	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	772,232	89,603	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	96,587	199,689	29,845,380	3,462,991	865,560	30.00
31.00	03100	INTENSIVE CARE UNIT	21,645	22,393	4,111,057	477,010	101,318	31.00
41.00	04100	SUBPROVIDER - IRF	13,962	52,408	6,325,990	734,011	397,447	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	82,022	669,594	15,768,826	1,829,673	638,902	50.00
51.00	05100	RECOVERY ROOM	0	48,124	1,334,447	154,837	96,669	51.00
53.00	05300	ANESTHESIOLOGY	7,759	99,574	3,274,894	379,989	644	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,442	202,006	4,396,345	510,112	157,142	54.00
56.00	05600	RADIOISOTOPE	354	59,143	1,033,234	119,887	33,067	56.00
57.00	05700	CT SCAN	5,270	521,480	2,110,032	244,829	40,338	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	894	173,513	1,606,907	186,451	44,411	58.00
60.00	06000	LABORATORY	73,946	673,486	10,345,607	1,200,411	129,736	60.00
65.00	06500	RESPIRATORY THERAPY	4,948	70,867	3,198,807	371,161	58,425	65.00
66.00	06600	PHYSICAL THERAPY	1,541	290,615	12,398,006	1,438,553	13,646	66.00
69.00	06900	ELECTROCARDIOLOGY	2,052	185,489	3,365,406	390,491	62,268	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	82,011	96,106	3,164,512	367,181	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	134,315	6,857,282	795,657	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	560	226,240	11,298,865	1,311,019	43,606	73.00
76.97	07697	CARDIAC REHABILITATION	63	10,586	792,634	91,970	147,616	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,297	27,126	704,601	81,756	0	90.00
91.00	09100	EMERGENCY	43,679	310,703	8,638,862	1,002,376	206,156	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	442,590	4,073,460	158,432,810	16,465,264	3,380,299	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	18,190	2,111	19,790	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	86	0	473,219	54,908	0	192.00
192.01	19201	OUTREACH LAB	0	0	0	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	16,544	1,920	0	192.02
192.03	19203	VACANT SPACE	0	0	39,721	4,609	43,215	192.03
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	442,676	4,073,460	158,980,484	16,528,812	3,443,304	202.00

## COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
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Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
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
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE	965,050					8.00
9.00	00900	HOUSEKEEPING	0	2,314,481				9.00
10.00	01000	DIETARY	0	59,407	1,472,644			10.00
11.00	01100	CAFETERIA	0	65,235	0	1,457,715		11.00
13.00	01300	NURSING ADMINISTRATION	0	21,724	0	30,245	1,960,414	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	45,859	0	5,915	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	13,924	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	718,687	592,571	1,096,700	351,326	916,873	30.00
31.00	03100	INTENSIVE CARE UNIT	69,466	69,363	106,003	58,451	98,699	31.00
41.00	04100	SUBPROVIDER - IRF	176,897	272,095	269,941	114,008	178,015	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	437,397	0	124,318	254,655	50.00
51.00	05100	RECOVERY ROOM	0	66,181	0	20,672	48,465	51.00
53.00	05300	ANESTHESIOLOGY	0	441	0	22,984	30,818	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	107,581	0	62,929	28,471	54.00
56.00	05600	RADIOISOTOPE	0	22,638	0	4,925	0	56.00
57.00	05700	CT SCAN	0	27,616	0	18,907	2,437	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	30,404	0	12,335	0	58.00
60.00	06000	LABORATORY	0	88,819	0	73,451	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	39,998	0	34,931	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,342	0	247,183	37,747	66.00
69.00	06900	ELECTROCARDIOLOGY	0	42,629	0	48,439	61,179	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	29,853	0	83,903	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	101,059	0	11,359	6,031	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	10,617	19,379	90.00
91.00	09100	EMERGENCY	0	141,136	0	105,776	277,645	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	965,050	2,271,348	1,472,644	1,456,598	1,960,414	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,548	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OUTREACH LAB	0	0	0	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	0	1,117	0	192.02
192.03	19203	VACANT SPACE	0	29,585	0	0	0	192.03
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)	965,050	2,314,481	1,472,644	1,457,715	1,960,414	202.00

## COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0011

Period:  
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Cost Center Description			CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	16.00	19.00	24.00	25.00	
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
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	743,493					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	875,759				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	42,950	0	37,893,038	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,816	0	5,096,183	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	11,272	0	8,479,676	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	144,019	0	19,197,790	0	50.00
51.00	05100	RECOVERY ROOM	0	10,351	0	1,731,622	0	51.00
53.00	05300	ANESTHESIOLOGY	0	21,417	0	3,731,187	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	43,448	0	5,306,028	0	54.00
56.00	05600	RADIOISOTOPE	0	12,721	0	1,226,472	0	56.00
57.00	05700	CT SCAN	0	112,162	0	2,556,321	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	37,320	0	1,917,828	0	58.00
60.00	06000	LABORATORY	83,185	144,479	0	12,065,688	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	15,242	0	3,718,564	0	65.00
66.00	06600	PHYSICAL THERAPY	0	62,507	0	14,206,984	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	39,896	0	4,010,308	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	660,308	20,671	0	4,212,672	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	28,889	0	7,681,828	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	48,661	0	12,815,907	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	2,277	0	1,152,946	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	5,834	0	822,187	0	90.00
91.00	09100	EMERGENCY	0	66,827	0	10,438,778	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	743,493	875,759	0	158,262,007	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	53,639	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	528,127	0	192.00
192.01	19201	OUTREACH LAB	0	0	0	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	0	19,581	0	192.02
192.03	19203	VACANT SPACE	0	0	0	117,130	0	192.03
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	743,493	875,759	0	158,980,484	0	202.00

## COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
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Part I  
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Cost Center Description		Total	
		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
5.01	00550	DATA PROCESSING	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	5.04
6.00	00600	MAINTENANCE & REPAIRS	6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	77.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM	102.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	OUTREACH LAB	192.01
192.02	19202	THERAPY CASH BASED SERVICES	192.02
192.03	19203	VACANT SPACE	192.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

## COST ALLOCATION STATISTICS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023

Worksheet Non-CMS W

Date/Time Prepared:  
8/30/2023 10:53 am

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.01	DATA PROCESSING	5	NUMBER OF PCS	5.01
5.02	PURCHASING RECEIVING AND STORES	6	PURCHASING SUPPLIES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	7	GROSS REVENUE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	-5	ACCUM. COST	5.04
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
8.00	LAUNDRY & LINEN SERVICE	8	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	9	MEALS SERVED	10.00
11.00	CAFETERIA	4	GROSS SALARIES	11.00
13.00	NURSING ADMINISTRATION	10	DIRECT NURS. HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
16.00	MEDICAL RECORDS & LIBRARY	7	GROSS REVENUE	16.00
19.00	NONPHYSICIAN ANESTHETISTS	19	ASSIGNED TIME	19.00

## ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet B  
Part II  
Date/Time Prepared:  
8/30/2023 10:53 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	34,518	4,207	38,725	4.00
5.01	00550	DATA PROCESSING	0	21,722	0	21,722	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	39,467	0	39,467	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	35,470	1,154	36,624	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	877,750	0	877,750	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	599,495	3,410	602,905	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	560	560	8.00
9.00	00900	HOUSEKEEPING	0	57,509	10,046	67,555	9.00
10.00	01000	DIETARY	0	79,759	6,967	86,726	10.00
11.00	01100	CAFETERIA	0	87,585	10,747	98,332	11.00
13.00	01300	NURSING ADMINISTRATION	0	29,167	245,511	274,678	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	61,570	170,355	231,925	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	795,583	309,885	1,105,468	30.00
31.00	03100	INTENSIVE CARE UNIT	0	93,126	275,609	368,735	31.00
41.00	04100	SUBPROVIDER - IRF	0	365,314	99,650	464,964	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	587,248	1,760,201	2,347,449	50.00
51.00	05100	RECOVERY ROOM	0	88,854	0	88,854	51.00
53.00	05300	ANESTHESIOLOGY	0	592	31,134	31,726	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	144,438	507,059	651,497	54.00
56.00	05600	RADIOISOTOPE	0	30,394	613	31,007	56.00
57.00	05700	CT SCAN	0	37,077	16,769	53,846	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	40,821	545,263	586,084	58.00
60.00	06000	LABORATORY	0	119,247	395,259	514,506	60.00
65.00	06500	RESPIRATORY THERAPY	0	53,702	148,138	201,840	65.00
66.00	06600	PHYSICAL THERAPY	0	12,542	60,626	73,168	66.00
69.00	06900	ELECTROCARDIOLOGY	0	57,234	348,245	405,479	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	40,081	154,310	194,391	73.00
76.97	07697	CARDIAC REHABILITATION	0	135,682	47,908	183,590	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	29,866	29,866	90.00
91.00	09100	EMERGENCY	0	189,489	133,042	322,531	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,715,436	5,316,534	10,031,970	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,190	0	18,190	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	9,763	9,763	192.00
192.01	19201	OUTREACH LAB	0	0	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	0	0	192.02
192.03	19203	VACANT SPACE	0	39,721	0	39,721	192.03
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,773,347	5,326,297	10,099,644	202.00

## ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet B  
Part II  
Date/Time Prepared:  
8/30/2023 10:53 am

Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.01	5.02	5.03	5.04	6.00	
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
5.01	00550	DATA PROCESSING	21,722					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	282	39,907				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	897	90	38,376			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	999	46	0	880,180		5.04
6.00	00600	MAINTENANCE & REPAIRS	410	0	0	19,064	622,821	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	26	0	0	5,343	0	8.00
9.00	00900	HOUSEKEEPING	77	1	0	12,468	11,317	9.00
10.00	01000	DIETARY	205	1	0	7,344	15,696	10.00
11.00	01100	CAFETERIA	0	2	0	7,182	17,236	11.00
13.00	01300	NURSING ADMINISTRATION	128	0	0	10,391	5,740	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	26	0	0	3,459	12,116	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	512	0	0	4,772	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,864	8,708	1,887	184,384	156,560	30.00
31.00	03100	INTENSIVE CARE UNIT	461	1,951	212	25,402	18,326	31.00
41.00	04100	SUBPROVIDER - IIRF	2,229	1,259	495	39,088	71,890	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,715	7,394	6,329	97,436	115,564	50.00
51.00	05100	RECOVERY ROOM	333	0	455	8,246	17,485	51.00
53.00	05300	ANESTHESIOLOGY	26	699	941	20,236	117	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	743	220	1,909	27,165	28,424	54.00
56.00	05600	RADIOISOTOPE	77	32	559	6,384	5,981	56.00
57.00	05700	CT SCAN	26	475	4,929	13,038	7,296	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	77	81	1,640	9,929	8,033	58.00
60.00	06000	LABORATORY	1,153	6,666	6,241	63,926	23,467	60.00
65.00	06500	RESPIRATORY THERAPY	564	446	670	19,765	10,568	65.00
66.00	06600	PHYSICAL THERAPY	3,023	139	2,747	76,607	2,468	66.00
69.00	06900	ELECTROCARDIOLOGY	743	185	1,753	20,795	11,263	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,393	908	19,554	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,270	42,371	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	435	50	2,138	69,816	7,887	73.00
76.97	07697	CARDIAC REHABILITATION	231	6	100	4,898	26,701	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	333	117	256	4,354	0	90.00
91.00	09100	EMERGENCY	1,127	3,938	2,937	53,380	37,289	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,722	39,899	38,376	876,797	611,424	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	112	3,580	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8	0	2,924	0	192.00
192.01	19201	OUTREACH LAB	0	0	0	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	0	102	0	192.02
192.03	19203	VACANT SPACE	0	0	0	245	7,817	192.03
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)	21,722	39,907	38,376	880,180	622,821	202.00

## ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet B  
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8/30/2023 10:53 am

Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
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
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,959					8.00
9.00	00900	HOUSEKEEPING	0	92,262				9.00
10.00	01000	DIETARY	0	2,368	112,688			10.00
11.00	01100	CAFETERIA	0	2,600	0	125,889		11.00
13.00	01300	NURSING ADMINISTRATION	0	866	0	2,612	295,125	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,828	0	511	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,202	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,438	23,623	83,921	30,349	138,029	30.00
31.00	03100	INTENSIVE CARE UNIT	429	2,765	8,111	5,048	14,858	31.00
41.00	04100	SUBPROVIDER - IRF	1,092	10,847	20,656	9,845	26,799	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	17,436	0	10,735	38,336	50.00
51.00	05100	RECOVERY ROOM	0	2,638	0	1,785	7,296	51.00
53.00	05300	ANESTHESIOLOGY	0	18	0	1,985	4,639	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,288	0	5,434	4,286	54.00
56.00	05600	RADIOISOTOPE	0	902	0	425	0	56.00
57.00	05700	CT SCAN	0	1,101	0	1,633	367	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,212	0	1,065	0	58.00
60.00	06000	LABORATORY	0	3,541	0	6,343	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,594	0	3,016	0	65.00
66.00	06600	PHYSICAL THERAPY	0	372	0	21,345	5,683	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,699	0	4,183	9,210	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,190	0	7,245	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	4,029	0	981	908	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	917	2,917	90.00
91.00	09100	EMERGENCY	0	5,626	0	9,134	41,797	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,959	90,543	112,688	125,793	295,125	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	540	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OUTREACH LAB	0	0	0	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	0	96	0	192.02
192.03	19203	VACANT SPACE	0	1,179	0	0	0	192.03
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)	5,959	92,262	112,688	125,889	295,125	202.00



## ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet B  
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Cost Center Description			CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	16.00	19.00	24.00	25.00	
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
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	250,004					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,813				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	347		1,749,829	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	39		447,709	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	91		651,930	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,162		2,647,473	0	50.00
51.00	05100	RECOVERY ROOM	0	84		127,661	0	51.00
53.00	05300	ANESTHESIOLOGY	0	173		61,099	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	351		725,794	0	54.00
56.00	05600	RADIOISOTOPE	0	103		45,586	0	56.00
57.00	05700	CT SCAN	0	905		84,060	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	301		608,711	0	58.00
60.00	06000	LABORATORY	27,972	910		656,449	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	123		239,406	0	65.00
66.00	06600	PHYSICAL THERAPY	0	505		191,858	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	322		456,769	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	222,032	167		250,054	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	233		43,874	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	393		285,514	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	18		221,729	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	47		39,056	0	90.00
91.00	09100	EMERGENCY	0	539		480,780	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	250,004	6,813	0	10,015,341	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		22,422	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		12,695	0	192.00
192.01	19201	OUTREACH LAB	0	0		0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0		224	0	192.02
192.03	19203	VACANT SPACE	0	0		48,962	0	192.03
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	250,004	6,813	0	10,099,644	0	202.00

## ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description		Total	
		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
5.01	00550	DATA PROCESSING	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	5.04
6.00	00600	MAINTENANCE & REPAIRS	6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	77.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM	102.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	OUTREACH LAB	192.01
192.02	19202	THERAPY CASH BASED SERVICES	192.02
192.03	19203	VACANT SPACE	192.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

## COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023

Worksheet B-1

Date/Time Prepared:  
8/30/2023 10:53 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (NUMBER OF PCS)	PURCHASING RECEIVING AND STORES (PURCHASING SUPPLIES)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	225,683				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,008,219			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,632	2,376	56,853,533		4.00
5.01	00550	DATA PROCESSING	1,027	0	0	848	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	1,866	0	232,613	11	9,688,247
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,677	652	1,123,959	35	21,931
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	41,500	0	2,033,734	39	11,149
6.00	00600	MAINTENANCE & REPAIRS	28,344	1,926	649,185	16	55
8.00	00800	LAUNDRY & LINEN SERVICE	0	316	44,538	1	0
9.00	00900	HOUSEKEEPING	2,719	5,674	1,239,087	3	123
10.00	01000	DIETARY	3,771	3,935	510,630	8	326
11.00	01100	CAFETERIA	4,141	6,070	787,880	0	502
13.00	01300	NURSING ADMINISTRATION	1,379	138,661	1,042,215	5	0
14.00	01400	CENTRAL SERVICES & SUPPLY	2,911	96,214	203,834	1	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	479,815	20	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	37,615	175,019	12,106,851	151	2,113,890
31.00	03100	INTENSIVE CARE UNIT	4,403	155,660	2,014,171	18	473,706
41.00	04100	SUBPROVIDER - IRF	17,272	56,281	3,928,598	87	305,571
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	27,765	994,137	4,283,869	106	1,795,109
51.00	05100	RECOVERY ROOM	4,201	0	712,325	13	0
53.00	05300	ANESTHESIOLOGY	28	17,584	792,015	1	169,821
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,829	286,380	2,168,459	29	53,440
56.00	05600	RADIOISOTOPE	1,437	346	169,708	3	7,741
57.00	05700	CT SCAN	1,753	9,471	651,529	1	115,327
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,930	307,957	425,054	3	19,563
60.00	06000	LABORATORY	5,638	223,237	2,531,033	45	1,618,366
65.00	06500	RESPIRATORY THERAPY	2,539	83,666	1,203,674	22	108,296
66.00	06600	PHYSICAL THERAPY	593	34,241	8,517,679	118	33,719
69.00	06900	ELECTROCARDIOLOGY	2,706	196,684	1,669,159	29	44,911
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,794,869
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,895	87,152	2,891,225	17	12,247
76.97	07697	CARDIAC REHABILITATION	6,415	27,058	391,417	9	1,371
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	16,868	365,864	13	28,382
91.00	09100	EMERGENCY	8,959	75,140	3,644,928	44	955,944
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	222,945	3,002,705	56,815,048	848	9,686,359
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	860	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,514	0	0	1,888
192.01	19201	OUTREACH LAB	0	0	0	0	0
192.02	19202	THERAPY CASH BASED SERVICES	0	0	38,485	0	0
192.03	19203	VACANT SPACE	1,878	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	4,773,347	5,326,297	14,641,766	8,892,269	442,676
203.00		Unit cost multiplier (Wkst. B, Part I)	21.150672	1.770582	0.257535	10,486.166274	0.045692
204.00		Cost to be allocated (per Wkst. B, Part II)			38,725	21,722	39,907
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000681	25.615566	0.004119
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

## COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023

Worksheet B-1

Date/Time Prepared:  
8/30/2023 10:53 am

Cost Center Description			CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
			5.03	5A.04	5.04	6.00	8.00	
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
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	785,728,706					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	-16,528,812	142,451,672			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	3,085,312	149,637		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	864,716	0	31,647	8.00
9.00	00900	HOUSEKEEPING	0	0	2,017,788	2,719	0	9.00
10.00	01000	DIETARY	0	0	1,188,553	3,771	0	10.00
11.00	01100	CAFETERIA	0	0	1,162,325	4,141	0	11.00
13.00	01300	NURSING ADMINISTRATION	552	0	1,681,596	1,379	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	559,782	2,911	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	772,232	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	38,520,292	0	29,845,380	37,615	23,568	30.00
31.00	03100	INTENSIVE CARE UNIT	4,319,569	0	4,111,057	4,403	2,278	31.00
41.00	04100	SUBPROVIDER - IRF	10,109,594	0	6,325,990	17,272	5,801	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	129,165,443	0	15,768,826	27,765	0	50.00
51.00	05100	RECOVERY ROOM	9,283,142	0	1,334,447	4,201	0	51.00
53.00	05300	ANESTHESIOLOGY	19,207,911	0	3,274,894	28	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,967,179	0	4,396,345	6,829	0	54.00
56.00	05600	RADIOISOTOPE	11,408,761	0	1,033,234	1,437	0	56.00
57.00	05700	CT SCAN	100,594,109	0	2,110,032	1,753	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	33,470,865	0	1,606,907	1,930	0	58.00
60.00	06000	LABORATORY	129,869,910	0	10,345,607	5,638	0	60.00
65.00	06500	RESPIRATORY THERAPY	13,670,279	0	3,198,807	2,539	0	65.00
66.00	06600	PHYSICAL THERAPY	56,060,018	0	12,398,006	593	0	66.00
69.00	06900	ELECTROCARDIOLOGY	35,780,982	0	3,365,406	2,706	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,538,949	0	3,164,512	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,909,455	0	6,857,282	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,641,990	0	11,298,865	1,895	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,042,098	0	792,634	6,415	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,232,706	0	704,601	0	0	90.00
91.00	09100	EMERGENCY	59,934,902	0	8,638,862	8,959	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPICD TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	785,728,706	-16,528,812	141,903,998	146,899	31,647	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	18,190	860	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	473,219	0	0	192.00
192.01	19201	OUTREACH LAB	0	0	0	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	16,544	0	0	192.02
192.03	19203	VACANT SPACE	0	0	39,721	1,878	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,073,460		16,528,812	3,443,304	965,050	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.005184		0.116031	23.011047	30.494202	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	38,376		880,180	622,821	5,959	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000049		0.006179	4.162213	0.188296	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: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023

Worksheet B-1

Date/Time Prepared:  
8/30/2023 10:53 am

Cost Center Description			HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	146,918					9.00
10.00	01000	DIETARY	3,771	94,941				10.00
11.00	01100	CAFETERIA	4,141	0	50,231,907			11.00
13.00	01300	NURSING ADMINISTRATION	1,379	0	1,042,215	587,336		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,911	0	203,834	0	3,362,620	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	479,815	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	37,615	70,704	12,106,851	274,693	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,403	6,834	2,014,171	29,570	0	31.00
41.00	04100	SUBPROVIDER - IRF	17,272	17,403	3,928,598	53,333	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	27,765	0	4,283,869	76,294	0	50.00
51.00	05100	RECOVERY ROOM	4,201	0	712,325	14,520	0	51.00
53.00	05300	ANESTHESIOLOGY	28	0	792,015	9,233	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,829	0	2,168,459	8,530	0	54.00
56.00	05600	RADIOISOTOPE	1,437	0	169,708	0	0	56.00
57.00	05700	CT SCAN	1,753	0	651,529	730	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,930	0	425,054	0	0	58.00
60.00	06000	LABORATORY	5,638	0	2,531,033	0	376,225	60.00
65.00	06500	RESPIRATORY THERAPY	2,539	0	1,203,674	0	0	65.00
66.00	06600	PHYSICAL THERAPY	593	0	8,517,679	11,309	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,706	0	1,669,159	18,329	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,986,395	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,895	0	2,891,225	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	6,415	0	391,417	1,807	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	365,864	5,806	0	90.00
91.00	09100	EMERGENCY	8,959	0	3,644,928	83,182	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	144,180	94,941	50,193,422	587,336	3,362,620	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	860	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OUTREACH LAB	0	0	0	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	38,485	0	0	192.02
192.03	19203	VACANT SPACE	1,878	0	0	0	0	192.03
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)	2,314,481	1,472,644	1,457,715	1,960,414	743,493	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.753556	15.511149	0.029020	3.337807	0.221105	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	92,262	112,688	125,889	295,125	250,004	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.627983	1.186927	0.002506	0.502481	0.074348	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: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023

Worksheet B-1

Date/Time Prepared:  
8/30/2023 10:53 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		16.00	19.00	
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
5.01	00550	DATA PROCESSING		5.01
5.02	00560	PURCHASING RECEIVING AND STORES		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL		5.04
6.00	00600	MAINTENANCE & REPAIRS		6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY	785,728,154	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	38,520,292	30.00
31.00	03100	INTENSIVE CARE UNIT	4,319,569	31.00
41.00	04100	SUBPROVIDER - IRF	10,109,594	41.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	129,165,443	50.00
51.00	05100	RECOVERY ROOM	9,283,142	51.00
53.00	05300	ANESTHESIOLOGY	19,207,911	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,967,179	54.00
56.00	05600	RADIOISOTOPE	11,408,761	56.00
57.00	05700	CT SCAN	100,594,109	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	33,470,865	58.00
60.00	06000	LABORATORY	129,869,910	60.00
65.00	06500	RESPIRATORY THERAPY	13,670,279	65.00
66.00	06600	PHYSICAL THERAPY	56,060,018	66.00
69.00	06900	ELECTROCARDIOLOGY	35,780,982	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,538,949	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,909,455	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,641,990	73.00
76.97	07697	CARDIAC REHABILITATION	2,042,098	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	77.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	5,232,706	90.00
91.00	09100	EMERGENCY	59,934,902	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	102.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	785,728,154	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	OUTREACH LAB	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	192.02
192.03	19203	VACANT SPACE	0	192.03
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)	875,759	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001115	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,813	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000009	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

Worksheet C  
Part I  
Date/Time Prepared:  
8/30/2023 10:53 am

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## COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet C  
Part I  
Date/Time Prepared:  
8/30/2023 10:53 am

			Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	29,741,462		29,741,462			30.00
31.00	03100	INTENSIVE CARE UNIT	4,319,569		4,319,569			31.00
41.00	04100	SUBPROVIDER - IRF	10,109,594		10,109,594			41.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	35,508,278	93,657,165	129,165,443	0.148629	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,063,047	6,220,095	9,283,142	0.186534	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	5,362,648	13,845,263	19,207,911	0.194253	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,128,704	33,838,474	38,967,178	0.136167	0.000000	54.00
56.00	05600	RADIOISOTOPE	1,516,308	9,892,453	11,408,761	0.107503	0.000000	56.00
57.00	05700	CT SCAN	22,758,155	77,835,953	100,594,108	0.025412	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,401,337	29,069,527	33,470,864	0.057298	0.000000	58.00
60.00	06000	LABORATORY	31,151,831	98,718,079	129,869,910	0.092906	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	11,184,382	2,482,834	13,667,216	0.272079	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	19,657,583	36,402,435	56,060,018	0.253425	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	9,306,391	26,474,591	35,780,982	0.112079	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,098,783	11,443,782	18,542,565	0.227189	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,978,092	17,931,363	25,909,455	0.296487	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,283,476	15,358,514	43,641,990	0.293660	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	1,988	2,040,110	2,042,098	0.564589	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	56,118	5,176,588	5,232,706	0.157125	0.000000	90.00
91.00	09100	EMERGENCY	16,554,311	43,380,591	59,934,902	0.174169	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,687,144	7,091,687	8,778,831	0.512315	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	254,869,201	530,859,504	785,728,705			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	254,869,201	530,859,504	785,728,705			202.00



## COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet C  
Part I  
Date/Time Prepared:  
8/30/2023 10:53 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVIDER - IRF				41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.148755			50.00
51.00	05100 RECOVERY ROOM	0.186534			51.00
53.00	05300 ANESTHESIOLOGY	0.194253			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.136167			54.00
56.00	05600 RADIOISOTOPE	0.107503			56.00
57.00	05700 CT SCAN	0.025412			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.057298			58.00
60.00	06000 LABORATORY	0.092906			60.00
65.00	06500 RESPIRATORY THERAPY	0.272385			65.00
66.00	06600 PHYSICAL THERAPY	0.253425			66.00
69.00	06900 ELECTROCARDIOLOGY	0.112079			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.227189			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.296487			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.293660			73.00
76.97	07697 CARDIAC REHABILITATION	0.564812			76.97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000			77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.157291			90.00
91.00	09100 EMERGENCY	0.174169			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.512315			92.00
OTHER REIMBURSABLE COST CENTERS					
102.00	10200 OPIOID TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

## COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet C  
Part I  
Date/Time Prepared:  
8/30/2023 10:53 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	37,893,038		37,893,038	0	37,893,038	30.00
31.00	03100	INTENSIVE CARE UNIT	5,096,183		5,096,183	0	5,096,183	31.00
41.00	04100	SUBPROVIDER - IRF	8,479,676		8,479,676	8,185	8,487,861	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	19,197,790		19,197,790	16,200	19,213,990	50.00
51.00	05100	RECOVERY ROOM	1,731,622		1,731,622	0	1,731,622	51.00
53.00	05300	ANESTHESIOLOGY	3,731,187		3,731,187	0	3,731,187	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,306,028		5,306,028	0	5,306,028	54.00
56.00	05600	RADIOISOTOPE	1,226,472		1,226,472	0	1,226,472	56.00
57.00	05700	CT SCAN	2,556,321		2,556,321	0	2,556,321	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,917,828		1,917,828	0	1,917,828	58.00
60.00	06000	LABORATORY	12,065,688		12,065,688	0	12,065,688	60.00
65.00	06500	RESPIRATORY THERAPY	3,718,564	0	3,718,564	4,175	3,722,739	65.00
66.00	06600	PHYSICAL THERAPY	14,206,984	0	14,206,984	0	14,206,984	66.00
69.00	06900	ELECTROCARDIOLOGY	4,010,308		4,010,308	0	4,010,308	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,212,672		4,212,672	0	4,212,672	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,681,828		7,681,828	0	7,681,828	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,815,907		12,815,907	0	12,815,907	73.00
76.97	07697	CARDIAC REHABILITATION	1,152,946		1,152,946	456	1,153,402	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	822,187		822,187	872	823,059	90.00
91.00	09100	EMERGENCY	10,438,778		10,438,778	0	10,438,778	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,497,526		4,497,526		4,497,526	92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	162,759,533	0	162,759,533	29,888	162,789,421	200.00
201.00		Less Observation Beds	4,497,526		4,497,526		4,497,526	201.00
202.00		Total (see instructions)	158,262,007	0	158,262,007	29,888	158,291,895	202.00

## COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet C  
Part I  
Date/Time Prepared:  
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			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	29,741,462		29,741,462		30.00
31.00	03100	INTENSIVE CARE UNIT	4,319,569		4,319,569		31.00
41.00	04100	SUBPROVIDER - IRF	10,109,594		10,109,594		41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	35,508,278	93,657,165	129,165,443	0.148629	50.00
51.00	05100	RECOVERY ROOM	3,063,047	6,220,095	9,283,142	0.186534	51.00
53.00	05300	ANESTHESIOLOGY	5,362,648	13,845,263	19,207,911	0.194253	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,128,704	33,838,474	38,967,178	0.136167	54.00
56.00	05600	RADIOISOTOPE	1,516,308	9,892,453	11,408,761	0.107503	56.00
57.00	05700	CT SCAN	22,758,155	77,835,953	100,594,108	0.025412	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,401,337	29,069,527	33,470,864	0.057298	58.00
60.00	06000	LABORATORY	31,151,831	98,718,079	129,869,910	0.092906	60.00
65.00	06500	RESPIRATORY THERAPY	11,184,382	2,482,834	13,667,216	0.272079	65.00
66.00	06600	PHYSICAL THERAPY	19,657,583	36,402,435	56,060,018	0.253425	66.00
69.00	06900	ELECTROCARDIOLOGY	9,306,391	26,474,591	35,780,982	0.112079	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,098,783	11,443,782	18,542,565	0.227189	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,978,092	17,931,363	25,909,455	0.296487	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,283,476	15,358,514	43,641,990	0.293660	73.00
76.97	07697	CARDIAC REHABILITATION	1,988	2,040,110	2,042,098	0.564589	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	56,118	5,176,588	5,232,706	0.157125	90.00
91.00	09100	EMERGENCY	16,554,311	43,380,591	59,934,902	0.174169	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,687,144	7,091,687	8,778,831	0.512315	92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	254,869,201	530,859,504	785,728,705		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	254,869,201	530,859,504	785,728,705		202.00

## COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet C  
Part I  
Date/Time Prepared:  
8/30/2023 10:53 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF				41.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000			77.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

## APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet D  
Part I  
Date/Time Prepared:  
8/30/2023 10:53 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	1,749,829	0	1,749,829	26,742	65.43	30.00	
31.00	INTENSIVE CARE UNIT	447,709		447,709	2,278	196.54	31.00	
41.00	SUBPROVIDER - IRF	651,930	0	651,930	5,801	112.38	41.00	
200.00	Total (lines 30 through 199)	2,849,468		2,849,468	34,821		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	12,034	787,385					30.00
31.00	INTENSIVE CARE UNIT	1,022	200,864					31.00
41.00	SUBPROVIDER - IRF	3,511	394,566					41.00
200.00	Total (lines 30 through 199)	16,567	1,382,815					200.00

## APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet D  
Part II  
Date/Time Prepared:  
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Cost Center Description			Title XVIII		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,647,473	129,165,443	0.020497	13,229,141	271,158
51.00	05100	RECOVERY ROOM	127,661	9,283,142	0.013752	1,180,671	16,237
53.00	05300	ANESTHESIOLOGY	61,099	19,207,911	0.003181	2,068,533	6,580
54.00	05400	RADIOLOGY-DIAGNOSTIC	725,794	38,967,178	0.018626	2,582,401	48,100
56.00	05600	RADIOISOTOPE	45,586	11,408,761	0.003996	760,851	3,040
57.00	05700	CT SCAN	84,060	100,594,108	0.000836	11,086,328	9,268
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	608,711	33,470,864	0.018186	1,763,486	32,071
60.00	06000	LABORATORY	656,449	129,869,910	0.005055	14,570,111	73,652
65.00	06500	RESPIRATORY THERAPY	239,406	13,667,216	0.017517	5,791,896	101,457
66.00	06600	PHYSICAL THERAPY	191,858	56,060,018	0.003422	5,367,168	18,366
69.00	06900	ELECTROCARDIOLOGY	456,769	35,780,982	0.012766	4,809,268	61,395
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	250,054	18,542,565	0.013485	2,211,498	29,822
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,874	25,909,455	0.001693	3,886,366	6,580
73.00	07300	DRUGS CHARGED TO PATIENTS	285,514	43,641,990	0.006542	12,160,405	79,553
76.97	07697	CARDIAC REHABILITATION	221,729	2,042,098	0.009157	1,183	128
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	39,056	5,232,706	0.007464	41,278	308
91.00	09100	EMERGENCY	480,780	59,934,902	0.008022	7,769,191	62,324
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	207,687	8,778,831	0.023658	804,000	19,021
200.00		Total (lines 50 through 199)	7,373,560	741,558,080		90,083,775	839,060

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0011		Period: From 04/01/2022 To 03/31/2023	Worksheet D Part III Date/Time Prepared: 8/30/2023 10:53 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	0
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0
200.00		Total (lines 30 through 199)	0	0	0	0	0	0
Cost Center Description				Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days
				4.00	5.00	6.00	7.00	8.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	26,742	0.00	12,034
31.00	03100	INTENSIVE CARE UNIT	0	0	0	2,278	0.00	1,022
41.00	04100	SUBPROVIDER - IRF	0	0	0	5,801	0.00	3,511
200.00		Total (lines 30 through 199)	0	0	0	34,821		16,567
Cost Center Description				Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost			
				9.00	13.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0			31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0			41.00
200.00		Total (lines 30 through 199)	0	0	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS  
THROUGH COSTS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet D  
Part IV  
Date/Time Prepared:  
8/30/2023 10:53 am

Cost Center Description			Title XVIII			Hospital		PPS
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet D  
Part IV  
Date/Time Prepared:  
8/30/2023 10:53 am

Cost Center Description			Title XVIII		Hospital		PPS	
			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	129,165,443	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	9,283,142	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	19,207,911	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	38,967,178	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	11,408,761	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	100,594,108	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	33,470,864	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	129,869,910	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,667,216	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	56,060,018	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	35,780,982	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	18,542,565	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	25,909,455	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	43,641,990	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,042,098	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	5,232,706	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	59,934,902	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	8,778,831	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	741,558,080		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet D  
Part IV  
Date/Time Prepared:  
8/30/2023 10:53 am

Cost Center Description			Title XVIII		Hospital		PPS	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	13,229,141	0	22,922,916	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,180,671	0	5,282,719	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,068,533	0	3,860,730	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,582,401	0	8,113,056	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	760,851	0	4,325,178	0	56.00
57.00	05700	CT SCAN	0.000000	11,086,328	0	26,392,938	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	1,763,486	0	8,672,249	0	58.00
60.00	06000	LABORATORY	0.000000	14,570,111	0	9,273,165	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	5,791,896	0	831,975	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	5,367,168	0	229,659	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	4,809,268	0	10,336,504	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,211,498	0	3,130,025	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,886,366	0	7,118,330	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	12,160,405	0	4,460,030	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	1,183	0	1,040,809	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	41,278	0	1,815,354	0	90.00
91.00	09100	EMERGENCY	0.000000	7,769,191	0	10,746,160	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	804,000	0	2,764,107	0	92.00
200.00		Total (lines 50 through 199)		90,083,775	0	131,315,904	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS  
THROUGH COSTS

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet D  
Part IV  
Date/Time Prepared:  
8/30/2023 10:53 am

				Title XVIII		Hospital		PPS	
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost					
			21.00	24.00					
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
56.00	05600	RADIOISOTOPE	0	0					56.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0					58.00
60.00	06000	LABORATORY	0	0					60.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0					77.00
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					92.00
200.00		Total (lines 50 through 199)	0	0					200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet D  
Part V  
Date/Time Prepared:  
8/30/2023 10:53 am

				Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.148629	22,922,916	0	0	3,407,010	50.00	
51.00	05100	RECOVERY ROOM	0.186534	5,282,719	0	0	985,407	51.00	
53.00	05300	ANESTHESIOLOGY	0.194253	3,860,730	0	0	749,958	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136167	8,113,056	0	0	1,104,730	54.00	
56.00	05600	RADIOISOTOPE	0.107503	4,325,178	0	0	464,970	56.00	
57.00	05700	CT SCAN	0.025412	26,392,938	0	0	670,697	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.057298	8,672,249	0	0	496,903	58.00	
60.00	06000	LABORATORY	0.092906	9,273,165	0	0	861,533	60.00	
65.00	06500	RESPIRATORY THERAPY	0.272079	831,975	0	0	226,363	65.00	
66.00	06600	PHYSICAL THERAPY	0.253425	229,659	0	0	58,201	66.00	
69.00	06900	ELECTROCARDIOLOGY	0.112079	10,336,504	0	0	1,158,505	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.227189	3,130,025	0	0	711,107	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.296487	7,118,330	0	0	2,110,492	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293660	4,460,030	0	33,572	1,309,732	73.00	
76.97	07697	CARDIAC REHABILITATION	0.564589	1,040,809	0	0	587,629	76.97	
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.157125	1,815,354	0	0	285,237	90.00	
91.00	09100	EMERGENCY	0.174169	10,746,160	0	0	1,871,648	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.512315	2,764,107	0	0	1,416,093	92.00	
200.00		Subtotal (see instructions)		131,315,904	0	33,572	18,476,215	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		131,315,904	0	33,572	18,476,215	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet D  
Part V  
Date/Time Prepared:  
8/30/2023 10:53 am

				Title XVIII	Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,859		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	9,859		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	9,859		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0011	Period: From 04/01/2022 To 03/31/2023	Worksheet D Part II Date/Time Prepared: 8/30/2023 10:53 am		
				Component CCN: 14-T011				
				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,647,473	129,165,443	0.020497	241,702	4,954	50.00
51.00	05100	RECOVERY ROOM	127,661	9,283,142	0.013752	15,705	216	51.00
53.00	05300	ANESTHESIOLOGY	61,099	19,207,911	0.003181	32,223	103	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	725,794	38,967,178	0.018626	108,833	2,027	54.00
56.00	05600	RADIOISOTOPE	45,586	11,408,761	0.003996	0	0	56.00
57.00	05700	CT SCAN	84,060	100,594,108	0.000836	149,049	125	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	608,711	33,470,864	0.018186	24,120	439	58.00
60.00	06000	LABORATORY	656,449	129,869,910	0.005055	667,654	3,375	60.00
65.00	06500	RESPIRATORY THERAPY	239,406	13,667,216	0.017517	346,049	6,062	65.00
66.00	06600	PHYSICAL THERAPY	191,858	56,060,018	0.003422	6,324,482	21,642	66.00
69.00	06900	ELECTROCARDIOLOGY	456,769	35,780,982	0.012766	65,489	836	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	250,054	18,542,565	0.013485	21,650	292	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,874	25,909,455	0.001693	132,549	224	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	285,514	43,641,990	0.006542	986,383	6,453	73.00
76.97	07697	CARDIAC REHABILITATION	221,729	2,042,098	0.009079	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	39,056	5,232,706	0.007464	14,840	111	90.00
91.00	09100	EMERGENCY	480,780	59,934,902	0.008022	18,821	151	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	8,778,831	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	7,165,873	741,558,080		9,149,549	47,010	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0011 Component CCN: 14-T011		Period: From 04/01/2022 To 03/31/2023		Worksheet D Part IV Date/Time Prepared: 8/30/2023 10:53 am	
				Title XVIII		Subprovider - IRF		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	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0011 Component CCN: 14-T011		Period: From 04/01/2022 To 03/31/2023		Worksheet D Part IV Date/Time Prepared: 8/30/2023 10:53 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of col.s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col.s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	129,165,443	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	9,283,142	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	19,207,911	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	38,967,178	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	11,408,761	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	100,594,108	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	33,470,864	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	0	129,869,910	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	13,667,216	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	56,060,018	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	35,780,982	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	18,542,565	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	25,909,455	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	43,641,990	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	2,042,098	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	5,232,706	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0	59,934,902	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	8,778,831	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	741,558,080		200.00



APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0011

Period:

Worksheet D

Component CCN: 14-T011

From 04/01/2022  
To 03/31/2023Part IV  
Date/Time Prepared:  
8/30/2023 10:53 am

Title XVIII

Subprovider -

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	241,702	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	15,705	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.000000	32,223	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	108,833	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	149,049	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	24,120	0	0	0	58.00
60.00	06000 LABORATORY	0.000000	667,654	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	346,049	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	6,324,482	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	65,489	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	21,650	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	132,549	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	986,383	0	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	14,840	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	18,821	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		9,149,549	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0011 Component CCN: 14-T011		Period: From 04/01/2022 To 03/31/2023	Worksheet D Part IV Date/Time Prepared: 8/30/2023 10:53 am
			Title XVIII		Subprovider - IRF	PPS
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	50.00	
51.00	05100	RECOVERY ROOM	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00	
56.00	05600	RADIOISOTOPE	0	0	56.00	
57.00	05700	CT SCAN	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00	
60.00	06000	LABORATORY	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00	
76.97	07697	CARDIAC REHABILITATION	0	0	76.97	
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00	
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	90.00	
91.00	09100	EMERGENCY	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00	
200.00		Total (lines 50 through 199)	0	0	200.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0011	Period: From 04/01/2022 To 03/31/2023	Worksheet D-1 Date/Time Prepared: 8/30/2023 10:53 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)		26,742	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		26,742	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)		23,568	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)		12,034	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)		37,893,038	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)		37,893,038	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)		37,893,038	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)		1,416.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		17,052,058	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)		17,052,058	41.00

## COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023

Worksheet D-1

Date/Time Prepared:  
8/30/2023 10:53 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	5,096,183	2,278	2,237.13	1,022	2,286,347	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)					15,234,551	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)					34,572,956	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)					988,249	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					839,060	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,827,309	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					32,745,647	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)					3,174	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,416.99	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,497,526	89.00

## COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023

Worksheet D-1

Date/Time Prepared:  
8/30/2023 10:53 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,749,829	37,893,038	0.046178	4,497,526	207,687	90.00
91.00	Nursing Program cost	0	37,893,038	0.000000	4,497,526	0	91.00
92.00	Allied health cost	0	37,893,038	0.000000	4,497,526	0	92.00
93.00	All other Medical Education	0	37,893,038	0.000000	4,497,526	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0011 Component CCN: 14-T011	Period: From 04/01/2022 To 03/31/2023	Worksheet D-1 Date/Time Prepared: 8/30/2023 10:53 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,801	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,801	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)		5,801	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)		3,511	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)		8,487,861	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)		8,487,861	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)		8,487,861	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)		1,463.17	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,137,190	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		5,137,190	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0011	Period: From 04/01/2022 To 03/31/2023	Worksheet D-1	
				Component CCN: 14-T011		Date/Time Prepared: 8/30/2023 10:53 am	
				Title XVIII		Subprovider - IRF	PPS
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,171,033	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)					7,308,223	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)					394,566	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					47,010	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					441,576	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,866,647	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0011 Component CCN: 14-T011	Period: From 04/01/2022 To 03/31/2023	Worksheet D-1 Date/Time Prepared: 8/30/2023 10:53 am	
			Title XVIII	Subprovider - IRF	PPS	
Cost Center Description					1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	651,930	8,487,861	0.076807	0	90.00
91.00	Nursing Program cost	0	8,487,861	0.000000	0	91.00
92.00	Allied health cost	0	8,487,861	0.000000	0	92.00
93.00	All other Medical Education	0	8,487,861	0.000000	0	93.00



INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0011	Period: From 04/01/2022 To 03/31/2023	Worksheet D-3  Date/Time Prepared: 8/30/2023 10:53 am
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		14,057,708	30.00
31.00	03100	INTENSIVE CARE UNIT		1,945,068	31.00
41.00	04100	SUBPROVIDER - IRF		1,077	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.148755	13,229,141	50.00
51.00	05100	RECOVERY ROOM	0.186534	1,180,671	51.00
53.00	05300	ANESTHESIOLOGY	0.194253	2,068,533	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136167	2,582,401	54.00
56.00	05600	RADIOISOTOPE	0.107503	760,851	56.00
57.00	05700	CT SCAN	0.025412	11,086,328	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.057298	1,763,486	58.00
60.00	06000	LABORATORY	0.092906	14,570,111	60.00
65.00	06500	RESPIRATORY THERAPY	0.272385	5,791,896	65.00
66.00	06600	PHYSICAL THERAPY	0.253425	5,367,168	66.00
69.00	06900	ELECTROCARDIOLOGY	0.112079	4,809,268	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.227189	2,211,498	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.296487	3,886,366	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293660	12,160,405	73.00
76.97	07697	CARDIAC REHABILITATION	0.564812	1,183	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.157291	41,278	90.00
91.00	09100	EMERGENCY	0.174169	7,769,191	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.512315	804,000	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		90,083,775	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)		90,083,775	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0011 Component CCN: 14-T011	Period: From 04/01/2022 To 03/31/2023	Worksheet D-3 Date/Time Prepared: 8/30/2023 10:53 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVIDER - IRF		6,691,729		41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.148755	241,702	35,954	50.00
51.00	05100 RECOVERY ROOM	0.186534	15,705	2,930	51.00
53.00	05300 ANESTHESIOLOGY	0.194253	32,223	6,259	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.136167	108,833	14,819	54.00
56.00	05600 RADIOISOTOPE	0.107503	0	0	56.00
57.00	05700 CT SCAN	0.025412	149,049	3,788	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.057298	24,120	1,382	58.00
60.00	06000 LABORATORY	0.092906	667,654	62,029	60.00
65.00	06500 RESPIRATORY THERAPY	0.272385	346,049	94,259	65.00
66.00	06600 PHYSICAL THERAPY	0.253425	6,324,482	1,602,782	66.00
69.00	06900 ELECTROCARDIOLOGY	0.112079	65,489	7,340	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.227189	21,650	4,919	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.296487	132,549	39,299	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.293660	986,383	289,661	73.00
76.97	07697 CARDIAC REHABILITATION	0.564812	0	0	76.97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.157291	14,840	2,334	90.00
91.00	09100 EMERGENCY	0.174169	18,821	3,278	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.512315	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		9,149,549	2,171,033	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		9,149,549		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0011	Period: From 04/01/2022 To 03/31/2023	Worksheet E Part A Date/Time Prepared: 8/30/2023 10:53 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)			9,073,162	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			10,253,839	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)			216,016	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			327,017	2.04
3.00	Managed Care Simulated Payments			8,625,636	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			76.30	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)			0.00	5.00
5.01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)			0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)			0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)			0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)			0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)			0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21.00
22.00	IME payment adjustment (see instructions)			0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.01
29.00	Total IME payment ( sum of lines 22 and 28)			0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			6.91	30.00
31.00	Percentage of Medicaid patient days (see instructions)			14.92	31.00
32.00	Sum of lines 30 and 31			21.83	32.00
33.00	Allowable disproportionate share percentage (see instructions)			7.22	33.00
34.00	Disproportionate share adjustment (see instructions)			348,853	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0011	Period: From 04/01/2022 To 03/31/2023	Worksheet E Part A Date/Time Prepared: 8/30/2023 10:53 am	
		Title XVIII	Hospital	PPS	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
<b>Uncompensated Care Payment Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)	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)	859,881	929,741	35.02	
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	431,119	463,597	35.03	
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	894,716		36.00	
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>					
40.00	Total Medicare discharges (see instructions)	0		40.00	
		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)	21,113,603		47.00	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	23,429,223		48.00	
				<b>Amount</b>	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)		22,850,318	49.00	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,475,939	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		95,078	54.00	
54.01	Islet isolation add-on payment		0	54.01	
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00	
55.01	Cellular therapy acquisition cost (see instructions)		0	55.01	
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00	
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00	
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00	
59.00	Total (sum of amounts on lines 49 through 58)		24,421,335	59.00	
60.00	Primary payer payments		0	60.00	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		24,421,335	61.00	
62.00	Deductibles billed to program beneficiaries		2,406,296	62.00	
63.00	Coinurance billed to program beneficiaries		194,114	63.00	
64.00	Allowable bad debts (see instructions)		814,159	64.00	
65.00	Adjusted reimbursable bad debts (see instructions)		529,203	65.00	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		474,807	66.00	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		22,350,128	67.00	
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00	
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00	
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50	
70.75	N95 respirator payment adjustment amount (see instructions)		0	70.75	
70.87	Demonstration payment adjustment amount before sequestration		0	70.87	
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88	
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89	
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90	
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-24,775	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)		-270,331	70.94	
70.95	Recovery of accelerated depreciation		0	70.95	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0011	Period: From 04/01/2022 To 03/31/2023	Worksheet E Part A Date/Time Prepared: 8/30/2023 10:53 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3	0	0	70.98	
70.99	HAC adjustment amount (see instructions)		104,449	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		21,950,573	71.00	
71.01	Sequestration adjustment (see instructions)		384,135	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		21,222,872	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)		343,566	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		55,449	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)		870,737	865,978	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		1.0000000000	1.0000000000	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)		0.9802	0.9913	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		-17,241	-7,534	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

CALCULATION OF DSH PAYMENT PERCENTAGE				Provider CCN: 14-0011		Period: From 04/01/2022 To 03/31/2023		Worksheet DSH	
				Title XVIII		Hospital		PPS	
		Original .mcx Values	Adjusted .mcx Values	HFS Look Up	Override Value	Revised Value			
		1.00	2.00	3.00	4.00	5.00			
CALCULATION OF THE DSH PAYMENT PERCENTAGE									
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	6.91	0.00	0.00	0.00	0.00	1.00		
2.00	Percentage of Medicaid patient days to total days (From line 27)	14.92	0.00			14.92	2.00		
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	21.83	0.00			14.92	3.00		
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	MDH				MDH	4.00		
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	76.30	0.00			76.30	5.00		
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	7.22	0.00			0.00	6.00		
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				No	7.00		
8.00	S-2, Line 22	Yes				Yes	8.00		
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00		
10.00	S-2, Line 45	No				No	10.00		
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 geater than -0-)	Yes				Yes	11.00		
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00		
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13.00		
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	4.01	0.00	0.00	0.00	0.00	14.00		
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS									
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	510	0			510	15.00		
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	296	0			296	16.00		
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00		
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00		
18.01	N/A	0	0			0	18.01		
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	3,050	0			3,050	19.00		
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00		
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	3,856	0			3,856	21.00		
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	25,846	0			25,846	22.00		
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00		
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00		
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00		
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	25,846	0			25,846	26.00		
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	14.92	0.00			14.92	27.00		

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0011		Period: From 04/01/2022 To 03/31/2023		Worksheet DSH Date/Time Prepared: 8/30/2023 10:53 am	
		Title XVIII		Hospital		PPS	
		Original .mcrcx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	7.22		0.00	False	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	True	29.00
30.00	Line 28 or 29 as applicable		7.22		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		7.22		0.00		31.00
		Original .mcrcx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	True				True	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural	36.00

## CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023

Worksheet DSH

Date/Time Prepared:  
8/30/2023 10:53 am

Title XVIII

Hospital

PPS

		Revised		
		Percentage		
		6.00		
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00		29.00
30.00	Line 28 or 29 as applicable	0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00		31.00



## LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
8/30/2023 10:53 am

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	9,073,162	0	9,073,162		9,073,162	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,253,839	0		10,253,839	10,253,839	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	216,016	0	216,016		216,016	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	327,017	0		327,017	327,017	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	8,625,636	0	4,303,865	4,321,771	8,625,636	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0722	0.0722	0.0722	0.0722		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	348,853	0	163,771	185,082	348,853	11.00
11.01	Uncompensated care payments	36.00	894,716	0	431,119	463,597	894,716	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	21,113,603	0	9,884,068	11,229,535	21,113,603	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	23,429,223	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	22,850,318	0	9,884,068	12,966,250	22,850,318	15.00
16.00	Payment for inpatient program capital (From Wkst. L, Pt. I, if applicable)	50.00	1,475,939	0	700,532	775,407	1,475,939	16.00

## LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
8/30/2023 10:53 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
17.00	Special add-on payments for new technologies	54.00	95,078	0	58,353	36,725	95,078
17.01	Net organ acquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	10,642,953	13,778,382	24,421,335
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	1,429,293	0	679,313	749,980	1,429,293
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	46,646	0	21,219	25,427	46,646
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	1,475,939	0	700,532	775,407	1,475,939
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

## HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet E  
Part A Exhibit 5  
Date/Time Prepared:  
8/30/2023 10:53 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	9,073,162	9,073,162		9,073,162	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,253,839		10,253,839	10,253,839	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	216,016	216,016		216,016	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	327,017		327,017	327,017	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	8,625,636	4,303,865	4,321,771	8,625,636	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0722	0.0722	0.0722		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	348,853	163,771	185,082	348,853	11.00
11.01	Uncompensated care payments	36.00	894,716	431,119	463,597	894,716	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	21,113,603	9,884,068	11,229,535	21,113,603	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	23,429,223	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	22,850,318	9,884,068	12,966,250	22,850,318	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,475,939	700,532	775,407	1,475,939	16.00
17.00	Special add-on payments for new technologies	54.00	95,078	58,353	36,725	95,078	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			10,642,953	13,778,382	24,421,335	19.00

## HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet E  
Part A Exhibit 5  
Date/Time Prepared:  
8/30/2023 10:53 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,429,293	679,313	749,980	1,429,293	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	46,646	21,219	25,427	46,646	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,475,939	700,532	775,407	1,475,939	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-270,331	-180,804	-89,527	-270,331	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-24,775	-17,241	-7,534	-24,775	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		104,449	0	104,449	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0011	Period: From 04/01/2022 To 03/31/2023	Worksheet E Part B Date/Time Prepared: 8/30/2023 10:53 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		9,859	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		18,476,215	2.00
3.00	OPPS or REH payments		12,546,854	3.00
4.00	Outlier payment (see instructions)		31,847	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.804	5.00
6.00	Line 2 times line 5		14,854,877	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		84.68	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)		9,859	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		33,572	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)		33,572	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		33,572	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		23,713	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)		9,859	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)		12,578,701	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,154,923	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)		10,433,637	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
28.50	REH facility payment amount		0	28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)		10,433,637	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		10,433,637	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)		422,411	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		274,567	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		214,967	36.00
37.00	Subtotal (see instructions)		10,708,204	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.75	N95 respirator payment adjustment amount (see instructions)		0	39.75
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		10,708,204	40.00
40.01	Sequestration adjustment (see instructions)		187,394	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		10,557,887	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-37,077	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0011	Period: From 04/01/2022 To 03/31/2023	Worksheet E Part B Date/Time Prepared: 8/30/2023 10:53 am	
		Title XVIII	Hospital	PPS	
				Overrides	
				1.00	
WORKSHEET OVERRIDE VALUES					
112.00	Override of Ancillary service charges (line 12)			0	112.00
				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: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet E-1  
Part I  
Date/Time Prepared:  
8/30/2023 10:53 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		26,190,151		10,610,672	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	07/19/2022	1,201,611	07/19/2022	946	3.50	
3.51		03/27/2023	3,765,668	03/27/2023	51,839	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)		-4,967,279		-52,785	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)		21,222,872		10,557,887	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		343,566		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		37,077	6.02	
7.00	Total Medicare program liability (see instructions)		21,566,438		10,520,810	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

## ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0011

Period:

Worksheet E-1

Component CCN: 14-T011

From 04/01/2022

Part I

To 03/31/2023

Date/Time Prepared:

8/30/2023 10:53 am

Title XVIII

Subprovider -

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		6,048,580		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	03/27/2023	37,744		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)		-37,744		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6,010,836		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		52,296		0	6.02
7.00	Total Medicare program liability (see instructions)		5,958,540		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00



CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0011	Period: From 04/01/2022 To 03/31/2023	Worksheet E-1 Part II Date/Time Prepared: 8/30/2023 10:53 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (see instructions)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (see instructions)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE 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
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0011 Component CCN: 14-T011	Period: From 04/01/2022 To 03/31/2023	Worksheet E-3 Part III Date/Time Prepared: 8/30/2023 10:53 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			5,618,996 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0401 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			203,970 3.00
4.00	Outlier Payments			311,269 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			15.893151 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			6,134,235 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			6,134,235 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			6,134,235 19.00
20.00	Deductibles			64,104 20.00
21.00	Subtotal (line 19 minus line 20)			6,070,131 21.00
22.00	Coinurance			18,826 22.00
23.00	Subtotal (line 21 minus line 22)			6,051,305 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			20,565 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			13,367 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			13,345 26.00
27.00	Subtotal (sum of lines 23 and 25)			6,064,672 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.98	Recovery of accelerated depreciation.			0 31.98
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			6,064,672 32.00
32.01	Sequestration adjustment (see instructions)			106,132 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			6,010,836 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			-52,296 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			311,269 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.			0.000000 99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)			0.000000 99.01

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 14-0011	Period: From 04/01/2022 To 03/31/2023	Worksheet E-5  Date/Time Prepared: 8/30/2023 10:53 am
		Title XVIII		PPS
				1.00
TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0 1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0 2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)			0 3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)			0 4.00
5.00	The rate used to calculate the time value of money (see instructions)			0.00 5.00
6.00	Time value of money for operating expenses (see instructions)			0 6.00
7.00	Time value of money for capital related expenses (see instructions)			0 7.00

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

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023

Worksheet G

Date/Time Prepared:  
8/30/2023 10:53 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	-1,414,540	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	82,890,897	0	0	0	4.00
5.00	Other receivable	75,645	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-64,889,330	0	0	0	6.00
7.00	Inventory	2,430,325	0	0	0	7.00
8.00	Prepaid expenses	361,203	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	-581	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	19,453,619	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	5,503,016	0	0	0	12.00
13.00	Land improvements	6,299,239	0	0	0	13.00
14.00	Accumulated depreciation	-4,676,856	0	0	0	14.00
15.00	Buildings	103,159,895	0	0	0	15.00
16.00	Accumulated depreciation	-66,418,882	0	0	0	16.00
17.00	Leasehold improvements	35,549	0	0	0	17.00
18.00	Accumulated depreciation	-23,265	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	154,343	0	0	0	21.00
22.00	Accumulated depreciation	-146,818	0	0	0	22.00
23.00	Major movable equipment	40,668,840	0	0	0	23.00
24.00	Accumulated depreciation	-29,746,297	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)	54,808,764	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	999	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	1,328,358	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,329,357	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	75,591,740	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	4,918,270	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	5,752,897	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,383,260	0	0	0	40.00
41.00	Deferred income	1,740	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	4,840,483	0	0	0	43.00
44.00	Other current liabilities	1,832,668	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	18,729,318	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	35,547,282	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	933,840	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	36,481,122	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	55,210,440	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	20,381,300				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)	20,381,300	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	75,591,740	0	0	0	60.00

## STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023

Worksheet G-1

Date/Time Prepared:  
8/30/2023 10:53 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		5,363,131		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		15,018,168				2.00
3.00	Total (sum of line 1 and line 2)		20,381,299		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00	ROUNDING	1		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 lines 4-9)		1		0		10.00
11.00	Subtotal (line 3 plus line 10)		20,381,300		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)		20,381,300		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00	ROUNDING		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: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
8/30/2023 10:53 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
<b>General Inpatient Routine Services</b>					
1.00	Hospital	29,741,462		29,741,462	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	10,109,594		10,109,594	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)	39,851,056		39,851,056	10.00
<b>Intensive Care Type Inpatient Hospital Services</b>					
11.00	INTENSIVE CARE UNIT	4,319,569		4,319,569	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)	4,319,569		4,319,569	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	44,170,625		44,170,625	17.00
18.00	Ancillary services	192,401,004	475,210,086	667,611,090	18.00
19.00	Outpatient services	18,259,325	55,687,666	73,946,991	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
27.01	OTHER (SPECIFY)	0	0	0	27.01
27.99	EE CHARGES	267,439	14,235,504	14,502,943	27.99
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	255,098,393	545,133,256	800,231,649	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		158,389,315		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)		158,389,315		43.00

## STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0011

Period:  
From 04/01/2022  
To 03/31/2023

Worksheet G-3

Date/Time Prepared:  
8/30/2023 10:53 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	800,231,649	1.00
2.00	Less contractual allowances and discounts on patients' accounts	601,816,644	2.00
3.00	Net patient revenues (line 1 minus line 2)	198,415,005	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	158,389,315	4.00
5.00	Net income from service to patients (line 3 minus line 4)	40,025,690	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	1,026,152	6.00
7.00	Income from investments	1,397,591	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	12,912	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	506,640	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	46,147	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	564,613	22.00
23.00	Governmental appropriations	0	23.00
24.00	Other specify	32,231	24.00
24.50	COVID-19 PHE Funding	2,501,866	24.50
25.00	Total other income (sum of lines 6-24)	6,088,152	25.00
26.00	Total (line 5 plus line 25)	46,113,842	26.00
27.00	Corp Alloc Contr	31,095,674	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	31,095,674	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	15,018,168	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0011	Period: From 04/01/2022 To 03/31/2023	Worksheet L Parts I-III Date/Time Prepared: 8/30/2023 10:53 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		1,429,293	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		46,646	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)		70.81	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,475,939	12.00
		1.00		
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00