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: 14-1335	Period: From 07/01/2022 To 06/30/2023	Worksheet S Parts I-III Date/Time Prepared: 11/28/2023 5:06 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/28/2023 Time: 5:06 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HARVARD MEMORIAL HOSPITAL (14-1335) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Todd Anderson		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Todd Anderson			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	307,612	633,227	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	TOTAL	0	307,612	633,227	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: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2023 5:06 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 901 GRANT STREET	PO Box:			1.00
2.00	City: HARVARD	State: IL	Zip Code: 60033-	County: MC HENRY	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	HARVARD MEMORIAL HOSPITAL	141335	16984	1	01/01/2004	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	CARE CENTER	146014	99914		01/01/2002	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2022	06/30/2023	20.00
21.00	Type of Control (see instructions)	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.	N	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2023 5:06 pm

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

		Urban/Rural 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.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00

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		V	XVIII	XIX	
		1.00	2.00	3.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

			1.00
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2023 5:06 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2023 5:06 pm

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

			1.00	
	Long Term Care Hospital PPS			
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00
	TEFRA Providers			
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2023 5:06 pm

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

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

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

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

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2023 5:06 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	720,368	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0764	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: MERCY HOME OFFICE	Contractor's Name: NGS	Contractor's Number: 00450	141.00
142.00	Street: 1000 MINERAL POINT AVE	PO Box:		142.00
143.00	City: JANESVILLE	State: WI	Zip Code: 53547	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: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2023 5:06 pm

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

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	Y	Y	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
161.10	CORF		N	N	N	161.10

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/28/2023 5:06 pm

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

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

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

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/29/2023	Y	09/29/2023	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: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II Date/Time Prepared: 11/28/2023 5:06 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	Y	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.	Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	Y		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.	AMY	SEACRIST	41.00
42.00	Enter the employer/company name of the cost report preparer.	MERCY		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	8159715010	ASEACRIST@MHEMAIL.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1335	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part II Date/Time Prepared: 11/28/2023 5:06 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR OF REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2023 5:06 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	10	3,650	14,383.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		10	3,650	14,383.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	3	1,095	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		13	4,745	14,383.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	16	5,840		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	46.00	29	10,585			21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10				0	25.10
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		58				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2023 5:06 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	273	15	585			1.00
2.00	HMO and other (see instructions)	0	27				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	273	15	585			7.00
8.00	INTENSIVE CARE UNIT	7	0	21			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)	280	15	606	0.00	157.12	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	767	0	2,088	0.00	4.84	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			3,666	0.00	8.49	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
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
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	170.45	27.00
28.00	Observation Bed Days		4	276			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: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2023 5:06 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	93	5	212	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	93	5	212	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	0.00				136	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
25.10	CMHC - CORF	0.00					25.10
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 UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-10 | Date/Time Prepared: 11/28/2023 5:06 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.339320	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,623,236	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	1,551,852	5.00
6.00	Medicaid charges	13,198,570	6.00
7.00	Medicaid cost (line 1 times line 6)	4,478,539	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)	303,451	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	14,938	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	303,451	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	809,183	192,367	1,001,550	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	274,572	192,367	466,939	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)	274,572	192,367	466,939	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)	2,540,845	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	320,415	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	492,947	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,047,898	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	867,425	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,334,364	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,637,815	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/28/2023 5:06 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	1,091,043	1,091,043	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,872,592	1,872,592	-1,091,043	781,549	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,613,925	1,613,925	0	1,613,925	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,003,762	2,363,338	3,367,100	-537,227	2,829,873	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	669,504	669,504	-31,996	637,508	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	86,325	86,325	0	86,325	8.00
9.00	00900	HOUSEKEEPING	190,104	284,247	474,351	0	474,351	9.00
10.00	01000	DIETARY	504,866	192,113	696,979	0	696,979	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,119,399	98,676	1,218,075	152,556	1,370,631	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	139,118	10,506	149,624	0	149,624	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	972,982	166,255	1,139,237	-17,668	1,121,569	30.00
31.00	03100	INTENSIVE CARE UNIT	154,402	63,266	217,668	0	217,668	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	487,192	487,192	44.00
46.00	04600	OTHER LONG TERM CARE	1,574,409	455,618	2,030,027	-1,231,872	798,155	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,176,348	1,818,540	2,994,888	-1,165,167	1,829,721	50.00
51.00	05100	RECOVERY ROOM	998,373	186,827	1,185,200	0	1,185,200	51.00
53.00	05300	ANESTHESIOLOGY	8,265	1,771,555	1,779,820	0	1,779,820	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	828,564	166,982	995,546	-12,726	982,820	54.00
60.00	06000	LABORATORY	627,812	171,323	799,135	152,553	951,688	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	15,691	22,455	38,146	3,569	41,715	65.00
66.00	06600	PHYSICAL THERAPY	185,983	18,853	204,836	286,239	491,075	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	312,211	312,211	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	24,496	24,496	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	54,884	18,926	73,810	929,300	1,003,110	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	455,867	455,867	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	216,932	717,989	934,921	200,348	1,135,269	73.00
76.97	07697	CARDIAC REHABILITATION	5,810	12,683	18,493	26,121	44,614	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,100,599	2,954,562	4,055,161	-33,796	4,021,365	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,878,303	15,737,060	26,615,363	0	26,615,363	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	10,878,303	15,737,060	26,615,363	0	26,615,363	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/28/2023 5:06 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	1,091,043		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-3,641	777,908		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	95,903	1,709,828		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,620,526	4,450,399		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	689,300	1,326,808		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	86,325		8.00
9.00	00900	HOUSEKEEPING	0	474,351		9.00
10.00	01000	DIETARY	-115,540	581,439		10.00
11.00	01100	CAFETERIA	0	0		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	18,138	1,388,769		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,348	169,972		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
20.00	02000	NURSING PROGRAM	0	0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,121,569		30.00
31.00	03100	INTENSIVE CARE UNIT	0	217,668		31.00
44.00	04400	SKILLED NURSING FACILITY	6,000	493,192		44.00
46.00	04600	OTHER LONG TERM CARE	0	798,155		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,829,721		50.00
51.00	05100	RECOVERY ROOM	0	1,185,200		51.00
53.00	05300	ANESTHESIOLOGY	-1,706,171	73,649		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	982,820		54.00
60.00	06000	LABORATORY	0	951,688		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	41,715		65.00
66.00	06600	PHYSICAL THERAPY	0	491,075		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	312,211		67.00
68.00	06800	SPEECH PATHOLOGY	0	24,496		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	103,853	1,106,963		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,181	496,048		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	130,613	1,265,882		73.00
76.97	07697	CARDIAC REHABILITATION	0	44,614		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-596,340	3,425,025		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	303,170	26,918,533		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	303,170	26,918,533		200.00

RECLASSIFICATIONS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/28/2023 5:06 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - SNF/LONG TERM CARE EXP RECLASS				
1.00	SKILLED NURSING FACILITY	44.00	371,267	115,925	1.00
	TOTALS		371,267	115,925	
	B - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	455,867	1.00
	TOTALS		0	455,867	
	C - MANAGER/DIRECTOR RECLASS				
1.00	NURSING ADMINISTRATION	13.00	142,316	10,240	1.00
2.00	OTHER LONG TERM CARE	46.00	183,556	13,207	2.00
3.00	OPERATING ROOM	50.00	21,034	0	3.00
4.00	LABORATORY	60.00	116,026	8,348	4.00
5.00	RESPIRATORY THERAPY	65.00	3,961	303	5.00
6.00	CARDIAC REHABILITATION	76.97	24,368	1,753	6.00
7.00	EMERGENCY	91.00	12,115	0	7.00
	TOTALS		503,376	33,851	
	D - INTERCOMPANY TRANSACTIONS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	58,293	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	407,731	0	2.00
3.00	OPERATION OF PLANT	7.00	165,240	0	3.00
4.00	INTENSIVE CARE UNIT	31.00	3,249	0	4.00
5.00	OTHER LONG TERM CARE	46.00	3,083	0	5.00
6.00	OPERATING ROOM	50.00	0	8,435	6.00
7.00	RECOVERY ROOM	51.00	337	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	9,293	0	8.00
9.00	RESPIRATORY THERAPY	65.00	4,589	0	9.00
10.00	DRUGS CHARGED TO PATIENTS	73.00	86,419	0	10.00
11.00	CARDIAC REHABILITATION	76.97	9,876	0	11.00
	TOTALS		748,110	8,435	
	E - SNF AND LTC RECLASS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	7,981	2,492	1.00
2.00	LABORATORY	60.00	21,474	6,705	2.00
3.00	RESPIRATORY THERAPY	65.00	598	187	3.00
4.00	PHYSICAL THERAPY	66.00	218,169	68,122	4.00
5.00	OCCUPATIONAL THERAPY	67.00	237,922	74,289	5.00
6.00	SPEECH PATHOLOGY	68.00	18,667	5,829	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	59,943	18,717	7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	152,676	47,672	8.00
	TOTALS		717,430	224,013	
	F - DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,091,043	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	1,091,043	
	G - LOCUM SALARY RECLASS				
1.00	ANESTHESIOLOGY	53.00	1,455,225	0	1.00
2.00	EMERGENCY	91.00	1,712,015	0	2.00
	TOTALS		3,167,240	0	
	H - MEDICAL SUPPLIES CHARGED TO PATIENT				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	850,640	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
	TOTALS		0	850,640	
	I - BIOMEDICAL				
1.00	OPERATING ROOM	50.00	0	6,930	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	25,066	2.00
	TOTALS		0	31,996	
500.00	Grand Total: Increases		5,507,423	2,811,770	500.00

RECLASSIFICATIONS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/28/2023 5:06 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - SNF/LONG TERM CARE EXP RECLASS						
1.00	OTHER LONG TERM CARE	46.00	371,267	115,925	0		1.00
	TOTALS		371,267	115,925			
	B - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	455,867	0		1.00
	TOTALS		0	455,867			
	C - MANAGER/DIRECTOR RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	503,376	33,851	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	TOTALS		503,376	33,851			
	D - INTERCOMPANY TRANSACTIONS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	58,293	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	407,731	0		2.00
3.00	OPERATION OF PLANT	7.00	0	165,240	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	3,249	0		4.00
5.00	OTHER LONG TERM CARE	46.00	0	3,083	0		5.00
6.00	OPERATING ROOM	50.00	8,435	0	0		6.00
7.00	RECOVERY ROOM	51.00	0	337	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,293	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	4,589	0		9.00
10.00	DRUGS CHARGED TO PATIENTS	73.00	0	86,419	0		10.00
11.00	CARDIAC REHABILITATION	76.97	0	9,876	0		11.00
	TOTALS		8,435	748,110			
	E - SNF AND LTC RECLASS						
1.00	OTHER LONG TERM CARE	46.00	717,430	224,013	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	TOTALS		717,430	224,013			
	F - DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,091,043	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	1,091,043			
	G - LOCUM SALARY RECLASS						
1.00	ANESTHESIOLOGY	53.00	0	1,455,225	0		1.00
2.00	EMERGENCY	91.00	0	1,712,015	0		2.00
	TOTALS		0	3,167,240			
	H - MEDICAL SUPPLIES CHARGED TO PATIENT						
1.00	ADULTS & PEDIATRICS	30.00	0	17,668	0		1.00
2.00	OPERATING ROOM	50.00	0	737,264	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	48,265	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	1,480	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	52	0		5.00
6.00	EMERGENCY	91.00	0	45,911	0		6.00
	TOTALS		0	850,640			
	I - BIOMEDICAL						
1.00	OPERATION OF PLANT	7.00	0	31,996	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	31,996			
500.00	Grand Total: Decreases		1,600,508	6,718,685			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 11/28/2023 5:06 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	222,604	0	0	0	0	1.00
2.00	Land Improvements	883,085	6,480	0	6,480	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	22,895,287	45,537	0	45,537	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	19,433,152	432,909	0	432,909	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	43,434,128	484,926	0	484,926	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	43,434,128	484,926	0	484,926	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	222,604	0	1.00
2.00	Land Improvements	889,565	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	22,940,824	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	19,866,061	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	43,919,054	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	43,919,054	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 11/28/2023 5:06 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,606,369	0	266,223	0	0	2.00
3.00	Total (sum of lines 1-2)	1,606,369	0	266,223	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	1,872,592		2.00
3.00	Total (sum of lines 1-2)	0	1,872,592		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 11/28/2023 5:06 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	24,052,992	0	24,052,992	0.547666	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	19,866,062	0	19,866,062	0.452334	0	2.00
3.00	Total (sum of lines 1-2)	43,919,054	0	43,919,054	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,091,043	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	515,326	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,606,369	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,091,043	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	262,582	0	0	0	777,908	2.00
3.00	Total (sum of lines 1-2)	262,582	0	0	0	1,868,951	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/28/2023 5:06 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	A	-3,641	CAP REL COSTS-MVBLE EQUIP	2.00	11	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)	A	-3,069	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,486,329			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	3,805,056			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-115,540	DIETARY	10.00	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		0		0.00	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	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER OPERATING REVENUE	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/28/2023 5:06 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	OTHER OPERATING REVENUE	B	0	OPERATING ROOM	50.00	0	33.01
33.02	OTHER OPERATING REVENUE	B	-1,193	DRUGS CHARGED TO PATIENTS	73.00	0	33.02
34.00	ILLINOIS UNALLOWABLE REAL ESTAT	A	-8,802	OPERATION OF PLANT	7.00	0	34.00
35.00	LOBBYING EXPENSE	A	-1,502	ADMINISTRATIVE & GENERAL	5.00	0	35.00
37.00	HOSPITAL TAX	A	-881,709	ADMINISTRATIVE & GENERAL	5.00	0	37.00
39.00	CASH DISCOUNTS	B	-101	ADMINISTRATIVE & GENERAL	5.00	0	39.00
42.00	SNF TAX	A	0	SKILLED NURSING FACILITY	44.00	0	42.00
43.00	CARE CENTER TAX	A	0	OTHER LONG TERM CARE	46.00	0	43.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		303,170				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: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 11/28/2023 5:06 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE EMPLOYEE BENEFIT	159,519	63,616	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ADMIN & GENERAL	3,378,915	875,077	2.00
3.00	7.00	OPERATION OF PLANT	HOME OFFICE OPERATION OF PLA	701,171	0	3.00
3.01	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE MEDICAL SUPPLIES	103,853	0	3.01
3.02	72.00	IMPL. DEV. CHARGED TO PATIEN	HOME OFFICE IMPLANT	40,181	0	3.02
3.07	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE DRUGS	131,806	0	3.07
3.10	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE MEDICAL RECORDS	20,348	0	3.10
3.11	13.00	NURSING ADMINISTRATION	HOME OFFICE NURSING ADMIN	175,985	0	3.11
3.12	0.00			0	0	3.12
3.14	44.00	SKILLED NURSING FACILITY	MED DIRECTOR DIRECT ALLOC	6,000	0	3.14
3.16	53.00	ANESTHESIOLOGY	PHYSICIAN BENEFITS	25,971	0	3.16
3.17	0.00			0	0	3.17
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,743,749	938,693	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-1335	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-1 Date/Time Prepared: 11/28/2023 5:06 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	95,903	0		1.00
2.00	2,503,838	0		2.00
3.00	701,171	0		3.00
3.01	103,853	0		3.01
3.02	40,181	0		3.02
3.07	131,806	0		3.07
3.10	20,348	0		3.10
3.11	175,985	0		3.11
3.12	0	0		3.12
3.14	6,000	9		3.14
3.16	25,971	0		3.16
3.17	0	0		3.17
4.00	0	0		4.00
5.00	3,805,056			5.00

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

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

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

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

6.00	HEALTH SYSTEM		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 11/28/2023 5:06 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	13.00	AGGREGATE-NURSING ADMINISTRATION	157,847	157,847	0	0	0	1.00
2.00	50.00	AGGREGATE-OPERATING ROOM	43,392	0	43,392	0	0	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	1,732,142	1,732,142	0	0	0	3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	91.00	AGGREGATE-EMERGENCY	2,458,335	596,340	1,861,995	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,391,716	2,486,329	1,905,387		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	13.00	AGGREGATE-NURSING ADMINISTRATION	0	0	0	0	0	1.00
2.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	13.00	AGGREGATE-NURSING ADMINISTRATION	0	0	0	157,847		1.00
2.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0		2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	1,732,142		3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0		4.00
5.00	91.00	AGGREGATE-EMERGENCY	0	0	0	596,340		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,486,329		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/28/2023 5:06 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,091,043	1,091,043				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	777,908		777,908			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,709,828	0	0	1,709,828		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,450,399	130,822	6,432	324,718	4,912,371	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,326,808	216,997	54,997	0	1,598,802	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	86,325	12,593	912	0	99,830	8.00
9.00	00900	HOUSEKEEPING	474,351	4,961	985	23,263	503,560	9.00
10.00	01000	DIETARY	581,439	33,567	14,443	61,780	691,229	10.00
11.00	01100	CAFETERIA	0	18,044	0	0	18,044	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,388,769	6,051	56,066	135,080	1,585,966	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	169,972	23,237	0	17,024	210,233	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,121,569	90,958	57,607	119,064	1,389,198	30.00
31.00	03100	INTENSIVE CARE UNIT	217,668	25,049	1,143	18,894	262,754	31.00
44.00	04400	SKILLED NURSING FACILITY	493,192	65,050	4,837	45,432	608,511	44.00
46.00	04600	OTHER LONG TERM CARE	798,155	111,741	8,493	81,898	1,000,287	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,829,721	109,111	338,742	145,491	2,423,065	50.00
51.00	05100	RECOVERY ROOM	1,185,200	4,361	5,628	122,171	1,317,360	51.00
53.00	05300	ANESTHESIOLOGY	73,649	0	414	0	74,063	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	982,820	28,825	157,892	102,368	1,271,905	54.00
60.00	06000	LABORATORY	951,688	20,811	5,660	93,651	1,071,810	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	41,715	17,581	9,628	2,478	71,402	65.00
66.00	06600	PHYSICAL THERAPY	491,075	49,213	3,079	49,456	592,823	66.00
67.00	06700	OCCUPATIONAL THERAPY	312,211	0	3,100	29,115	344,426	67.00
68.00	06800	SPEECH PATHOLOGY	24,496	0	243	2,284	27,023	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,106,963	0	3,995	14,051	1,125,009	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	496,048	0	0	0	496,048	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,265,882	7,359	1,989	45,229	1,320,459	73.00
76.97	07697	CARDIAC REHABILITATION	44,614	6,814	9,297	3,693	64,418	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,425,025	19,802	32,326	272,688	3,749,841	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,918,533	1,002,947	777,908	1,709,828	26,830,437	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	88,096	0	0	88,096	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	26,918,533	1,091,043	777,908	1,709,828	26,918,533	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/28/2023 5:06 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,912,371					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	356,896	0	1,955,698			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,285	0	33,136	155,251		8.00
9.00	00900	HOUSEKEEPING	112,408	0	13,054	22,552	651,574	9.00
10.00	01000	DIETARY	154,301	0	88,328	0	30,140	10.00
11.00	01100	CAFETERIA	4,028	0	47,481	0	16,202	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	354,030	0	15,923	0	5,433	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	46,930	0	61,145	0	20,864	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	310,107	0	239,343	20,412	81,670	30.00
31.00	03100	INTENSIVE CARE UNIT	58,654	0	65,914	47	22,492	31.00
44.00	04400	SKILLED NURSING FACILITY	135,836	0	171,169	9,580	58,407	44.00
46.00	04600	OTHER LONG TERM CARE	223,291	0	294,034	16,820	100,332	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	540,894	0	287,111	29,350	97,970	50.00
51.00	05100	RECOVERY ROOM	294,070	0	11,476	7,337	3,916	51.00
53.00	05300	ANESTHESIOLOGY	16,533	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	283,924	0	75,848	8,252	25,881	54.00
60.00	06000	LABORATORY	239,257	0	54,761	554	18,686	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	15,939	0	46,262	7,720	15,786	65.00
66.00	06600	PHYSICAL THERAPY	132,334	0	129,498	5,803	44,188	66.00
67.00	06700	OCCUPATIONAL THERAPY	76,885	0	0	6,139	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,032	0	0	481	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	251,132	0	0	1,547	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	110,731	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	294,762	0	19,365	3,940	6,608	73.00
76.97	07697	CARDIAC REHABILITATION	14,380	0	17,931	67	6,119	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	837,067	0	52,107	14,650	17,780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,892,706	0	1,723,886	155,251	572,474	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	19,665	0	231,812	0	79,100	192.00
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)	4,912,371	0	1,955,698	155,251	651,574	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/28/2023 5:06 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	963,998					10.00
11.00	01100	CAFETERIA	301,000	386,755				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	33,975	0	1,995,327		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,137	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,813	37,831	0	392,510	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,628	0	28,034	0	31.00
44.00	04400	SKILLED NURSING FACILITY	131,798	18,665	0	82,440	0	44.00
46.00	04600	OTHER LONG TERM CARE	231,414	32,741	0	144,748	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	147	55,415	0	306,410	0	50.00
51.00	05100	RECOVERY ROOM	0	39,335	0	387,463	0	51.00
53.00	05300	ANESTHESIOLOGY	0	694	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,832	32,316	0	29,144	0	54.00
60.00	06000	LABORATORY	7,632	33,820	0	4,769	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	221	733	0	139	0	65.00
66.00	06600	PHYSICAL THERAPY	77,457	19,667	0	48,443	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	84,463	11,955	0	52,825	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,620	926	0	4,132	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,277	7,327	0	13,310	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	54,212	11,916	0	33,913	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,003	0	139	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,112	35,671	0	466,908	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	963,998	386,755	0	1,995,327	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
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)	963,998	386,755	0	1,995,327	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/28/2023 5:06 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	0					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	347,309				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING PROGRAM	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	15,848	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	674	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	226,258	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	56,648	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7,081	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	40,800	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	347,309	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	347,309	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/28/2023 5:06 pm

		Cost Center Description	INTERNS & RESIDENTS					
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			21.00	22.00	23.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	2,526,732	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	443,197	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	1,216,406	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	2,043,667	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	3,966,620	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,060,957	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	91,290	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,786,750	0	54.00
60.00	06000	LABORATORY	0	0	0	1,431,289	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	158,202	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,057,294	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	576,693	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	45,214	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,419,602	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	606,779	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,745,175	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	104,057	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	5,219,936	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	26,499,860	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	418,673	0	192.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	26,918,533	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/28/2023 5:06 pm

		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
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING PROGRAM			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,526,732		30.00
31.00	03100	INTENSIVE CARE UNIT	443,197		31.00
44.00	04400	SKILLED NURSING FACILITY	1,216,406		44.00
46.00	04600	OTHER LONG TERM CARE	2,043,667		46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	3,966,620		50.00
51.00	05100	RECOVERY ROOM	2,060,957		51.00
53.00	05300	ANESTHESIOLOGY	91,290		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,786,750		54.00
60.00	06000	LABORATORY	1,431,289		60.00
60.01	06001	BLOOD LABORATORY	0		60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62.30
65.00	06500	RESPIRATORY THERAPY	158,202		65.00
66.00	06600	PHYSICAL THERAPY	1,057,294		66.00
67.00	06700	OCCUPATIONAL THERAPY	576,693		67.00
68.00	06800	SPEECH PATHOLOGY	45,214		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,419,602		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	606,779		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,745,175		73.00
76.97	07697	CARDIAC REHABILITATION	104,057		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		76.98
76.99	07699	LITHOTRIPSY	0		76.99
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	5,219,936		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	0		99.10
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,499,860		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS PRIVATE OFFICES	418,673		192.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	26,918,533		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/28/2023 5:06 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	142,595	130,822	6,432	279,849	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	27,439	216,997	54,997	299,433	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,593	912	13,505	0	8.00
9.00	00900	HOUSEKEEPING	0	4,961	985	5,946	0	9.00
10.00	01000	DIETARY	399	33,567	14,443	48,409	0	10.00
11.00	01100	CAFETERIA	0	18,044	0	18,044	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	6,051	56,066	62,117	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,237	0	23,237	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,062	90,958	57,607	154,627	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	25,049	1,143	26,192	0	31.00
44.00	04400	SKILLED NURSING FACILITY	1,508	65,050	4,837	71,395	0	44.00
46.00	04600	OTHER LONG TERM CARE	11,048	111,741	8,493	131,282	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,232	109,111	338,742	465,085	0	50.00
51.00	05100	RECOVERY ROOM	1,126	4,361	5,628	11,115	0	51.00
53.00	05300	ANESTHESIOLOGY	488	0	414	902	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	243	28,825	157,892	186,960	0	54.00
60.00	06000	LABORATORY	1,615	20,811	5,660	28,086	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2	17,581	9,628	27,211	0	65.00
66.00	06600	PHYSICAL THERAPY	909	49,213	3,079	53,201	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	967	0	3,100	4,067	0	67.00
68.00	06800	SPEECH PATHOLOGY	76	0	243	319	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	244	0	3,995	4,239	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	7,359	1,989	9,348	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	6,814	9,297	16,111	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,025	19,802	32,326	54,153	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	213,978	1,002,947	777,908	1,994,833	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	88,096	0	88,096	0	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	213,978	1,091,043	777,908	2,082,929	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/28/2023 5:06 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	279,849					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	20,332	0	319,765			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,270	0	5,418	20,193		8.00
9.00	00900	HOUSEKEEPING	6,404	0	2,134	2,933	17,417	9.00
10.00	01000	DIETARY	8,790	0	14,442	0	806	10.00
11.00	01100	CAFETERIA	229	0	7,763	0	433	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	20,169	0	2,603	0	145	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,674	0	9,997	0	558	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,666	0	39,134	2,655	2,183	30.00
31.00	03100	INTENSIVE CARE UNIT	3,341	0	10,777	6	601	31.00
44.00	04400	SKILLED NURSING FACILITY	7,738	0	27,987	1,246	1,561	44.00
46.00	04600	OTHER LONG TERM CARE	12,721	0	48,078	2,188	2,682	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,814	0	46,944	3,818	2,619	50.00
51.00	05100	RECOVERY ROOM	16,753	0	1,876	954	105	51.00
53.00	05300	ANESTHESIOLOGY	942	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,175	0	12,401	1,073	692	54.00
60.00	06000	LABORATORY	13,630	0	8,954	72	499	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	908	0	7,564	1,004	422	65.00
66.00	06600	PHYSICAL THERAPY	7,539	0	21,173	755	1,181	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,380	0	0	798	0	67.00
68.00	06800	SPEECH PATHOLOGY	344	0	0	63	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,307	0	0	201	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,308	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,792	0	3,166	512	177	73.00
76.97	07697	CARDIAC REHABILITATION	819	0	2,932	9	164	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	47,684	0	8,520	1,906	475	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	278,729	0	281,863	20,193	15,303	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,120	0	37,902	0	2,114	192.00
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)	279,849	0	319,765	20,193	17,417	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/28/2023 5:06 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	72,447					10.00
11.00	01100	CAFETERIA	22,620	49,089				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	4,312	0	89,346		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,033	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,992	4,802	0	17,576	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	587	0	1,255	0	31.00
44.00	04400	SKILLED NURSING FACILITY	9,905	2,369	0	3,691	0	44.00
46.00	04600	OTHER LONG TERM CARE	17,391	4,156	0	6,481	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11	7,034	0	13,720	0	50.00
51.00	05100	RECOVERY ROOM	0	4,993	0	17,350	0	51.00
53.00	05300	ANESTHESIOLOGY	0	88	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	213	4,102	0	1,305	0	54.00
60.00	06000	LABORATORY	574	4,293	0	214	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	17	93	0	6	0	65.00
66.00	06600	PHYSICAL THERAPY	5,821	2,496	0	2,169	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,348	1,517	0	2,365	0	67.00
68.00	06800	SPEECH PATHOLOGY	498	117	0	185	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,599	930	0	596	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	4,074	1,512	0	1,519	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	127	0	6	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	384	4,528	0	20,908	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	72,447	49,089	0	89,346	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
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)	72,447	49,089	0	89,346	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/28/2023 5:06 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	0					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	37,499				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING PROGRAM	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,711	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0	73	0			31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0			44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	24,429	0			50.00
51.00	05100	RECOVERY ROOM	0	0	0			51.00
53.00	05300	ANESTHESIOLOGY	0	0	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,116	0			54.00
60.00	06000	LABORATORY	0	0	0			60.00
60.01	06001	BLOOD LABORATORY	0	0	0			60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0			65.00
66.00	06600	PHYSICAL THERAPY	0	765	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0			73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	4,405	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	37,499	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0			192.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	37,499	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/28/2023 5:06 pm

		Cost Center Description	INTERNS & RESIDENTS: SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS: SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			21.00	22.00	23.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				243,346	0	30.00
31.00	03100	INTENSIVE CARE UNIT				42,832	0	31.00
44.00	04400	SKILLED NURSING FACILITY				125,892	0	44.00
46.00	04600	OTHER LONG TERM CARE				224,979	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM				594,474	0	50.00
51.00	05100	RECOVERY ROOM				53,146	0	51.00
53.00	05300	ANESTHESIOLOGY				1,932	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				229,037	0	54.00
60.00	06000	LABORATORY				56,322	0	60.00
60.01	06001	BLOOD LABORATORY				0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				37,225	0	65.00
66.00	06600	PHYSICAL THERAPY				95,100	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				19,475	0	67.00
68.00	06800	SPEECH PATHOLOGY				1,526	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				21,872	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				6,308	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				37,100	0	73.00
76.97	07697	CARDIAC REHABILITATION				20,168	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY				142,963	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	1,953,697	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES				129,232	0	192.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	2,082,929	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/28/2023 5:06 pm

		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
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING PROGRAM			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	243,346		30.00
31.00	03100	INTENSIVE CARE UNIT	42,832		31.00
44.00	04400	SKILLED NURSING FACILITY	125,892		44.00
46.00	04600	OTHER LONG TERM CARE	224,979		46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	594,474		50.00
51.00	05100	RECOVERY ROOM	53,146		51.00
53.00	05300	ANESTHESIOLOGY	1,932		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	229,037		54.00
60.00	06000	LABORATORY	56,322		60.00
60.01	06001	BLOOD LABORATORY	0		60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62.30
65.00	06500	RESPIRATORY THERAPY	37,225		65.00
66.00	06600	PHYSICAL THERAPY	95,100		66.00
67.00	06700	OCCUPATIONAL THERAPY	19,475		67.00
68.00	06800	SPEECH PATHOLOGY	1,526		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,872		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,308		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,100		73.00
76.97	07697	CARDIAC REHABILITATION	20,168		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		76.98
76.99	07699	LITHOTRIPSY	0		76.99
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	142,963		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	0		99.10
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,953,697		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS PRIVATE OFFICES	129,232		192.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,082,929		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/28/2023 5:06 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	80,055					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		750,838				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	13,972,653			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,599	6,208	2,653,608	-4,912,371	22,006,162	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	15,922	53,083	0	0	1,598,802	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	924	880	0	0	99,830	8.00
9.00	00900	HOUSEKEEPING	364	951	190,104	0	503,560	9.00
10.00	01000	DIETARY	2,463	13,940	504,866	0	691,229	10.00
11.00	01100	CAFETERIA	1,324	0	0	0	18,044	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	444	54,115	1,103,868	0	1,585,966	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,705	0	139,118	0	210,233	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,674	55,602	972,982	0	1,389,198	30.00
31.00	03100	INTENSIVE CARE UNIT	1,838	1,103	154,402	0	262,754	31.00
44.00	04400	SKILLED NURSING FACILITY	4,773	4,669	371,267	0	608,511	44.00
46.00	04600	OTHER LONG TERM CARE	8,199	8,197	669,268	0	1,000,287	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,006	326,955	1,188,947	0	2,423,065	50.00
51.00	05100	RECOVERY ROOM	320	5,432	998,373	0	1,317,360	51.00
53.00	05300	ANESTHESIOLOGY	0	400	0	0	74,063	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,115	152,398	836,545	0	1,271,905	54.00
60.00	06000	LABORATORY	1,527	5,463	765,312	0	1,071,810	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,290	9,293	20,250	0	71,402	65.00
66.00	06600	PHYSICAL THERAPY	3,611	2,972	404,152	0	592,823	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,992	237,922	0	344,426	67.00
68.00	06800	SPEECH PATHOLOGY	0	235	18,667	0	27,023	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,856	114,827	0	1,125,009	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	496,048	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	540	1,920	369,608	0	1,320,459	73.00
76.97	07697	CARDIAC REHABILITATION	500	8,973	30,178	0	64,418	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,453	31,201	2,228,389	0	3,749,841	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73,591	750,838	13,972,653	-4,912,371	21,918,066	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	6,464	0	0	0	88,096	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,091,043	777,908	1,709,828		4,912,371	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.628668	1.036053	0.122370		0.223227	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		279,849	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.012717	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: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/28/2023 5:06 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	54,534				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	924	151,285			8.00
9.00	00900	HOUSEKEEPING	0	364	21,976	53,246		9.00
10.00	01000	DIETARY	0	2,463	0	2,463	52,421	10.00
11.00	01100	CAFETERIA	0	1,324	0	1,324	16,368	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	444	0	444	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,705	0	1,705	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	6,674	19,891	6,674	2,165	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,838	46	1,838	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	4,773	9,335	4,773	7,167	44.00
46.00	04600	OTHER LONG TERM CARE	0	8,199	16,390	8,199	12,584	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	8,006	28,600	8,006	8	50.00
51.00	05100	RECOVERY ROOM	0	320	7,150	320	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,115	8,041	2,115	154	54.00
60.00	06000	LABORATORY	0	1,527	540	1,527	415	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,290	7,523	1,290	12	65.00
66.00	06600	PHYSICAL THERAPY	0	3,611	5,655	3,611	4,212	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	5,982	0	4,593	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	469	0	360	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,507	0	1,157	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	540	3,839	540	2,948	73.00
76.97	07697	CARDIAC REHABILITATION	0	500	65	500	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	1,453	14,276	1,453	278	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	48,070	151,285	46,782	52,421	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	6,464	0	6,464	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,955,698	155,251	651,574	963,998	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	35.861994	1.026215	12.237051	18.389539	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	319,765	20,193	17,417	72,447	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	5.863590	0.133477	0.327104	1.382022	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: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/28/2023 5:06 pm

		Cost Center Description	CAFETERIA (FULL TIME EQUIVALE)	MAINTENANCE OF PERSONNEL (FULL TIME EQUIVALE)	NURSING ADMINISTRATION (DIRECT NRS ING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	10,029					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	881	0	71,957			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	211	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	981	0	14,155	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	120	0	1,011	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	484	0	2,973	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	849	0	5,220	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,437	0	11,050	0	0	50.00
51.00	05100	RECOVERY ROOM	1,020	0	13,973	0	0	51.00
53.00	05300	ANESTHESIOLOGY	18	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	838	0	1,051	0	0	54.00
60.00	06000	LABORATORY	877	0	172	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	19	0	5	0	0	65.00
66.00	06600	PHYSICAL THERAPY	510	0	1,747	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	310	0	1,905	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	24	0	149	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	190	0	480	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	309	0	1,223	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	26	0	5	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	925	0	16,838	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,029	0	71,957	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
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)	386,755	0	1,995,327	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	38.563665	0.000000	27.729436	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	49,089	0	89,346	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.894705	0.000000	1.241658	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/28/2023 5:06 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,030					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING PROGRAM	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	47	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	671	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	168	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	21	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	121	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,030	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
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)	347,309	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	337.193204	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	37,499	0	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	36.406796	0.000000	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/28/2023 5:06 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)		
			22.00	23.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00	02000	NURSING PROGRAM				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
		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
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		192.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/28/2023 5:06 pm

Title XVIII | 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	2,526,732		2,526,732	0	2,526,732	30.00
31.00	03100	INTENSIVE CARE UNIT	443,197		443,197	0	443,197	31.00
44.00	04400	SKILLED NURSING FACILITY	1,216,406		1,216,406	0	1,216,406	44.00
46.00	04600	OTHER LONG TERM CARE	2,043,667		2,043,667	0	2,043,667	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,966,620		3,966,620	0	3,966,620	50.00
51.00	05100	RECOVERY ROOM	2,060,957		2,060,957	0	2,060,957	51.00
53.00	05300	ANESTHESIOLOGY	91,290		91,290	0	91,290	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,786,750		1,786,750	0	1,786,750	54.00
60.00	06000	LABORATORY	1,431,289		1,431,289	0	1,431,289	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	158,202	0	158,202	0	158,202	65.00
66.00	06600	PHYSICAL THERAPY	1,057,294	0	1,057,294	0	1,057,294	66.00
67.00	06700	OCCUPATIONAL THERAPY	576,693	0	576,693	0	576,693	67.00
68.00	06800	SPEECH PATHOLOGY	45,214	0	45,214	0	45,214	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,419,602		1,419,602	0	1,419,602	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	606,779		606,779	0	606,779	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,745,175		1,745,175	0	1,745,175	73.00
76.97	07697	CARDIAC REHABILITATION	104,057		104,057	0	104,057	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,219,936		5,219,936	0	5,219,936	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	809,963		809,963		809,963	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
200.00		Subtotal (see instructions)	27,309,823	0	27,309,823	0	27,309,823	200.00
201.00		Less Observation Beds	809,963		809,963		809,963	201.00
202.00		Total (see instructions)	26,499,860	0	26,499,860	0	26,499,860	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/28/2023 5:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,549,219		2,549,219			30.00
31.00	03100	INTENSIVE CARE UNIT	164,703		164,703			31.00
44.00	04400	SKILLED NURSING FACILITY	495,597		495,597			44.00
46.00	04600	OTHER LONG TERM CARE	867,493		867,493			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,784,330	20,867,638	23,651,968	0.167708	0.000000	50.00
51.00	05100	RECOVERY ROOM	159,572	5,253,899	5,413,471	0.380709	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	14,758	14,758	6.185798	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	646,468	14,028,453	14,674,921	0.121755	0.000000	54.00
60.00	06000	LABORATORY	388,084	3,524,571	3,912,655	0.365810	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	21,525	63,449	84,974	1.861769	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	456,934	1,309,370	1,766,304	0.598591	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	317,597	0	317,597	1.815801	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	24,918	0	24,918	1.814512	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	642,866	4,830,096	5,472,962	0.259385	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	664,055	1,453,432	2,117,487	0.286556	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,075,849	5,870,188	6,946,037	0.251248	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	250,230	250,230	0.415845	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	214,528	8,388,654	8,603,182	0.606745	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	23,355	745,086	768,441	1.054034	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
200.00		Subtotal (see instructions)	11,497,093	66,599,824	78,096,917			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,497,093	66,599,824	78,096,917			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/28/2023 5:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
44.00	04400	SKILLED NURSING FACILITY			44.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.167708		50.00
51.00	05100	RECOVERY ROOM	0.380709		51.00
53.00	05300	ANESTHESIOLOGY	6.185798		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.121755		54.00
60.00	06000	LABORATORY	0.365810		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	1.861769		65.00
66.00	06600	PHYSICAL THERAPY	0.598591		66.00
67.00	06700	OCCUPATIONAL THERAPY	1.815801		67.00
68.00	06800	SPEECH PATHOLOGY	1.814512		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.259385		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.286556		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.251248		73.00
76.97	07697	CARDIAC REHABILITATION	0.415845		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.606745		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.054034		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
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: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/28/2023 5:06 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,526,732		2,526,732	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	443,197		443,197	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	1,216,406		1,216,406	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	2,043,667		2,043,667	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,966,620		3,966,620	0	0	50.00
51.00	05100	RECOVERY ROOM	2,060,957		2,060,957	0	0	51.00
53.00	05300	ANESTHESIOLOGY	91,290		91,290	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,786,750		1,786,750	0	0	54.00
60.00	06000	LABORATORY	1,431,289		1,431,289	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	158,202	0	158,202	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,057,294	0	1,057,294	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	576,693	0	576,693	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	45,214	0	45,214	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,419,602		1,419,602	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	606,779		606,779	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,745,175		1,745,175	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	104,057		104,057	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,219,936		5,219,936	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	809,963		809,963		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
200.00		Subtotal (see instructions)	27,309,823	0	27,309,823	0	0	200.00
201.00		Less Observation Beds	809,963		809,963		0	201.00
202.00		Total (see instructions)	26,499,860	0	26,499,860	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/28/2023 5:06 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
200.00		Subtotal (see instructions)	0	0	0			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	0	0	0			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/28/2023 5:06 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
44.00	04400	SKILLED NURSING FACILITY			44.00
46.00	04600	OTHER LONG TERM CARE			46.00
		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
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 11/28/2023 5:06 pm

Title XVIII | Hospital | Cost

		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	594,474	23,651,968	0.025134	906,163	22,776	50.00
51.00	05100	RECOVERY ROOM	53,146	5,413,471	0.009817	51,395	505	51.00
53.00	05300	ANESTHESIOLOGY	1,932	14,758	0.130912	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	229,037	14,674,921	0.015607	132,404	2,066	54.00
60.00	06000	LABORATORY	56,322	3,912,655	0.014395	157,836	2,272	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	37,225	84,974	0.438075	8,623	3,778	65.00
66.00	06600	PHYSICAL THERAPY	95,100	1,766,304	0.053841	84,245	4,536	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,475	317,597	0.061320	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,526	24,918	0.061241	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,872	5,472,962	0.003996	145,162	580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,308	2,117,487	0.002979	292,068	870	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,100	6,946,037	0.005341	361,075	1,929	73.00
76.97	07697	CARDIAC REHABILITATION	20,168	250,230	0.080598	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	142,963	8,603,182	0.016617	423	7	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	78,007	768,441	0.101513	0	0	92.00
200.00		Total (lines 50 through 199)	1,394,655	74,019,905		2,139,394	39,319	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/28/2023 5:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	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: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/28/2023 5:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	23,651,968	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,413,471	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	14,758	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,674,921	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	3,912,655	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	84,974	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,766,304	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	317,597	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	24,918	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,472,962	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,117,487	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,946,037	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	250,230	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	8,603,182	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	768,441	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	74,019,905		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/28/2023 5:06 pm

Title XVIII | Hospital | Cost

		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	906,163	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	51,395	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	132,404	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	157,836	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	8,623	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	84,245	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	145,162	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	292,068	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	361,075	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	423	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)		2,139,394	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/28/2023 5:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.167708	0	4,936,358	0	0	50.00
51.00	05100	RECOVERY ROOM	0.380709	0	1,348,322	0	0	51.00
53.00	05300	ANESTHESIOLOGY	6.185798	0	6,220	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.121755	0	4,040,670	0	0	54.00
60.00	06000	LABORATORY	0.365810	0	1,356,463	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1.861769	0	13,078	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.598591	0	297,063	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.815801	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.814512	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.259385	0	1,060,832	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.286556	0	417,519	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.251248	0	2,283,111	3,043	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.415845	0	177,091	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.606745	0	1,622,102	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.054034	0	329,177	0	0	92.00
200.00		Subtotal (see instructions)		0	17,888,006	3,043	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	17,888,006	3,043	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/28/2023 5:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	827,867	0		50.00
51.00	05100	RECOVERY ROOM	513,318	0		51.00
53.00	05300	ANESTHESIOLOGY	38,476	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	491,972	0		54.00
60.00	06000	LABORATORY	496,208	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	24,348	0		65.00
66.00	06600	PHYSICAL THERAPY	177,819	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	275,164	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	119,643	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	573,627	765		73.00
76.97	07697	CARDIAC REHABILITATION	73,642	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	984,202	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	346,964	0		92.00
200.00		Subtotal (see instructions)	4,943,250	765		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,943,250	765		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part I Date/Time Prepared: 11/28/2023 5:06 pm

Title XIX | Hospital | Cost

	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	243,346	0	243,346	861	282.63	30.00
31.00	INTENSIVE CARE UNIT	42,832		42,832	21	2,039.62	31.00
44.00	SKILLED NURSING FACILITY	125,892		125,892	2,088	60.29	44.00
200.00	Total (lines 30 through 199)	412,070		412,070	2,970		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	15	4,239				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	15	4,239				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 11/28/2023 5:06 pm

Title XIX | Hospital | Cost

		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	594,474	0	0.000000	0	0	50.00
51.00	05100	RECOVERY ROOM	53,146	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1,932	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	229,037	0	0.000000	0	0	54.00
60.00	06000	LABORATORY	56,322	0	0.000000	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	37,225	0	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	95,100	0	0.000000	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,475	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,526	0	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,872	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,308	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,100	0	0.000000	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	20,168	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	142,963	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	78,007	0	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	1,394,655	0		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part III Date/Time Prepared: 11/28/2023 5:06 pm

Title XIX | Hospital | Cost

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	861	0.00	15	30.00
31.00	03100	INTENSIVE CARE UNIT		0	21	0.00	0	31.00
44.00	04400	SKILLED NURSING FACILITY		0	2,088	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	2,970		15	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/28/2023 5:06 pm

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	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: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/28/2023 5:06 pm

Title XIX | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/28/2023 5:06 pm

Title XIX | Hospital | Cost

		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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/28/2023 5:06 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	861	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	861	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)	585	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)	273	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		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)	2,526,732	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)	2,526,732	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)	2,526,732	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)	2,934.65	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	801,159	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)	801,159	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/28/2023 5:06 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	443,197	21	21,104.62	7	147,732	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)	524,202	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,473,093	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	276	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,934.65	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1335	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/28/2023 5:06 pm
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	809,963	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	243,346	2,526,732	0.096309	809,963	78,007	90.00
91.00	Nursing Program cost	0	2,526,732	0.000000	809,963	0	91.00
92.00	Allied health cost	0	2,526,732	0.000000	809,963	0	92.00
93.00	All other Medical Education	0	2,526,732	0.000000	809,963	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1335 Component CCN: 14-6014	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/28/2023 5:06 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,088	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,088	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,088	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)	767	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		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)	1,216,406	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)	1,216,406	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)	1,216,406	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1

Component CCN: 14-6014 | Date/Time Prepared: 11/28/2023 5:06 pm

Title XVIII | Skilled Nursing Facility | 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						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)		48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)		48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
55.01	Permanent adjustment amount per discharge		55.01
55.02	Adjustment amount per discharge (contractor use only)		55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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)		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)		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	1,216,406	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	582.57	71.00
72.00	Program routine service cost (line 9 x line 71)	446,831	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	446,831	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	446,831	83.00
84.00	Program inpatient ancillary services (see instructions)	691,213	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	1,138,044	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1335 Component CCN: 14-6014	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/28/2023 5:06 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description		
		1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
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	0	0	0.000000	0	0	90.00
91.00	Nursing Program cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/28/2023 5:06 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	861	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	861	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)	585	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)	15	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		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)	2,526,732	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)	2,526,732	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)	2,526,732	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)	2,934.65	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	44,020	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	44,020	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/28/2023 5:06 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	443,197	21	21,104.62	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)	0	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	44,020	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	276	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,934.65	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1335	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/28/2023 5:06 pm
	Title XIX	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	809,963	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	243,346	2,526,732	0.096309	809,963	78,007	90.00
91.00	Nursing Program cost	0	2,526,732	0.000000	809,963	0	91.00
92.00	Allied health cost	0	2,526,732	0.000000	809,963	0	92.00
93.00	All other Medical Education	0	2,526,732	0.000000	809,963	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/28/2023 5:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		895,878		30.00
31.00	03100	INTENSIVE CARE UNIT		52,960		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.167708	906,163	151,971	50.00
51.00	05100	RECOVERY ROOM	0.380709	51,395	19,567	51.00
53.00	05300	ANESTHESIOLOGY	6.185798	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.121755	132,404	16,121	54.00
60.00	06000	LABORATORY	0.365810	157,836	57,738	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1.861769	8,623	16,054	65.00
66.00	06600	PHYSICAL THERAPY	0.598591	84,245	50,428	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.815801	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.814512	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.259385	145,162	37,653	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.286556	292,068	83,694	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.251248	361,075	90,719	73.00
76.97	07697	CARDIAC REHABILITATION	0.415845	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.606745	423	257	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.054034	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,139,394	524,202	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)		2,139,394		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1335 | Component CCN: 14-6014 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/28/2023 5:06 pm

Title XVIII | Skilled Nursing Facility | 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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.167708	0	0	50.00
51.00	05100	RECOVERY ROOM	0.380709	0	0	51.00
53.00	05300	ANESTHESIOLOGY	6.185798	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.121755	7,751	944	54.00
60.00	06000	LABORATORY	0.365810	17,250	6,310	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1.861769	2,405	4,478	65.00
66.00	06600	PHYSICAL THERAPY	0.598591	228,040	136,503	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.815801	256,657	466,038	67.00
68.00	06800	SPEECH PATHOLOGY	1.814512	18,906	34,305	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.259385	9,951	2,581	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.286556	175	50	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.251248	159,210	40,001	73.00
76.97	07697	CARDIAC REHABILITATION	0.415845	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.606745	5	3	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.054034	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		700,350	691,213	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)		700,350		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E Part B Date/Time Prepared: 11/28/2023 5:06 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,944,015	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	4,650,893	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,944,015	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	4,993,455	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)	4,650,893	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	25,015	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,135,395	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)	1,833,045	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	1,833,045	30.00
31.00	Primary payer payments	646	31.00
32.00	Subtotal (line 30 minus line 31)	1,832,399	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)	468,391	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	304,454	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	211,651	36.00
37.00	Subtotal (see instructions)	2,136,853	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)		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)	2,136,853	40.00
40.01	Sequestration adjustment (see instructions)	42,737	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	1,460,889	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	633,227	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1335	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/28/2023 5:06 pm
	Title XVIII	Hospital	Cost

		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: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I Date/Time Prepared: 11/28/2023 5:06 pm

Title XVIII | Hospital | Cost

		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		963,539		1,460,702	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	02/21/2023	71,766	06/22/2023	187	3.01
3.02		06/22/2023	22,455		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		94,221		187	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)		1,057,760		1,460,889	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		307,612		633,227	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,365,372		2,094,116	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.	06101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1335 | Component CCN: 14-6014 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 11/28/2023 5:06 pm

Title XVIII | Skilled Nursing Facility | 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		406,833		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		406,833		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		0		0	6.02
7.00	Total Medicare program liability (see instructions)		406,833		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.	06101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1335	Period: From 07/01/2022 To 06/30/2023	Worksheet E-1 Part II Date/Time Prepared: 11/28/2023 5:06 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1335	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part V Date/Time Prepared: 11/28/2023 5:06 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,473,093	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	1,473,093	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,487,824	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,487,824	19.00
20.00	Deductibles (exclude professional component)	110,548	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,377,276	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,377,276	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	24,556	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	15,961	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,556	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,393,237	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,393,237	30.00
30.01	Sequestration adjustment (see instructions)	27,865	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,057,760	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	307,612	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1335 Component CCN: 14-6014	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part VI Date/Time Prepared: 11/28/2023 5:06 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	497,099	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	497,099	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	81,963	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	415,136	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.98	Recovery of accelerated depreciation.	0	14.98
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	415,136	15.00
15.01	Sequestration adjustment (see instructions)	8,303	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)	0	15.75
16.00	Interim payments	406,833	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-3 Part VII | Date/Time Prepared: 11/28/2023 5:06 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	44,020		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	44,020	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	44,020	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	44,020	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	44,020	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	44,020	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	44,020	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	44,020	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	44,020	0	36.00
37.00	PAYMENT	-44,020	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G | Date/Time Prepared: 11/28/2023 5:06 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,867,253	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	10,068,005	0	0	0	4.00
5.00	Other receivable	-84,364	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,552,961	0	0	0	6.00
7.00	Inventory	1,037,921	0	0	0	7.00
8.00	Prepaid expenses	37,428	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,373,282	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	222,604	0	0	0	12.00
13.00	Land improvements	889,565	0	0	0	13.00
14.00	Accumulated depreciation	-783,553	0	0	0	14.00
15.00	Buildings	22,941,824	0	0	0	15.00
16.00	Accumulated depreciation	-18,976,467	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	19,866,062	0	0	0	23.00
24.00	Accumulated depreciation	-16,751,785	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)	7,408,250	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	32,045	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	32,045	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	14,813,577	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	391,874	0	0	0	37.00
38.00	Salaries, wages, and fees payable	905,015	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	1,751,259	0	0	0	43.00
44.00	Other current liabilities	-19,652,504	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-16,604,356	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	9,619,738	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,619,738	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-6,984,618	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	21,798,195				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)	21,798,195	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	14,813,577	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-1 | Date/Time Prepared: 11/28/2023 5:06 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		16,906,608		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,926,061				2.00
3.00	Total (sum of line 1 and line 2)		20,832,669		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	OTHER	0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		20,832,669		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	OTHER	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)		20,832,669		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	OTHER		0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00	OTHER		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: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/28/2023 5:06 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,962,913		1,962,913	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	2,321,055		2,321,055	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,283,968		4,283,968	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	162,215		162,215	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)	162,215		162,215	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,446,183		4,446,183	17.00
18.00	Ancillary services	6,126,925	58,846,253	64,973,178	18.00
19.00	Outpatient services	216,385	8,467,808	8,684,193	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
24.10	CORF	0	0	0	24.10
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	PROFESSIONAL FEES	0	5,260,932	5,260,932	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,789,493	72,574,993	83,364,486	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		26,615,363		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BD	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)		26,615,363		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1335 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-3 | Date/Time Prepared: 11/28/2023 5:06 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	83,364,486	1.00
2.00	Less contractual allowances and discounts on patients' accounts	52,957,828	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,406,658	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,615,363	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,791,295	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	101	10.00
11.00	Rebates and refunds of expenses	2,556	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	114,176	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	0	24.00
24.50	COVID-19 PHE Funding	17,933	24.50
25.00	Total other income (sum of lines 6-24)	134,766	25.00
26.00	Total (line 5 plus line 25)	3,926,061	26.00
27.00	GRANT	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,926,061	29.00