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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0184	Period: From 01/14/2023 To 09/30/2023	Worksheet S Parts I-III Date/Time Prepared: 2/28/2024 12:49 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/28/2024 Time: 12:49 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 HEARTLAND REGIONAL MEDICAL CENTER (14-0184) for the cost reporting period beginning 01/14/2023 and ending 09/30/2023 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	Amber Lipe		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	Amber Lipe			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	-59,339	-137,607	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	-59,339	-137,607	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2024 12:49 pm

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

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	HEARTLAND REGIONAL MEDICAL CENTER	140184	16060	1	07/01/1996	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	HEARTLAND REGIONAL MEDICAL CENTER	14U184	16060		03/23/1999	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/14/2023	09/30/2023	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.	Y	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	Y		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2024 12:49 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.	15	130	0	0	774	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.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2024 12:49 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2024 12:49 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

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

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

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/28/2024 12:49 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	217,943	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.	Y	N	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0778	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: DEACONESS HEALTH SYSTEM	Contractor's Name: WPS	Contractor's Number: 08001	141.00
142.00	Street: 600 MARY STREET	PO Box:		142.00
143.00	City: EVANSVILLE	State: IN	Zip Code: 47710	143.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/28/2024 12:49 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/28/2024 12:49 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)	Y	01/14/2023	1.00

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

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

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

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	N	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	02/11/2024	Y	02/11/2024	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part II Date/Time Prepared: 2/28/2024 12:49 pm

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ERIC	HENDERSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	DEACONESS HEALTH SYSTEM		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	812-450-6856	ERIC.HENDERSON@DEACONESS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0184	Period: From 01/14/2023 To 09/30/2023	Worksheet S-2 Part II Date/Time Prepared: 2/28/2024 12:49 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 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: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/28/2024 12:49 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	76	19,760	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		76	19,760	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	18	4,680	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)		94	24,440	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		94				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/28/2024 12:49 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)	2,010	5	4,985			1.00
2.00	HMO and other (see instructions)	1,250	904				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)	2,010	5	4,985			7.00
8.00	INTENSIVE CARE UNIT	293	10	693			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)	2,303	15	5,678	0.00	180.50	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	180.50	27.00
28.00	Observation Bed Days		0	1,563			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/28/2024 12:49 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	606	50	1,563	1.00
2.00	HMO and other (see instructions)			247	232		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	606	50	1,563	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-3 Part II Date/Time Prepared: 2/28/2024 12:49 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	15,873,014	0	15,873,014	375,442.38	42.28	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		218,970	0	218,970	5,827.76	37.57	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		65,190	0	65,190	1,501.61	43.41	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		878,702	0	878,702	8,213.69	106.98	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		30,000	0	30,000	176.00	170.45	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		1,881,852	0	1,881,852	57,662.00	32.64	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		2,560,761	0	2,560,761			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		10,514	0	10,514			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		39,500	0	39,500			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		497,086	0	497,086			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-3 Part II Date/Time Prepared: 2/28/2024 12:49 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	265,615	0	265,615	4,500.00	59.03	26.00
27.00	Administrative & General	5.00	973,931	0	973,931	28,755.00	33.87	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	388,061	0	388,061	11,244.00	34.51	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		717,090	0	717,090	42,987.00	16.68	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		132,315	0	132,315	6,229.00	21.24	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	597,712	0	597,712	10,533.00	56.75	38.00
39.00	Central Services and Supply	14.00	198,922	0	198,922	8,778.00	22.66	39.00
40.00	Pharmacy	15.00	874,167	0	874,167	17,431.00	50.15	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	275,018	0	275,018	4,745.00	57.96	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-3 Part III Date/Time Prepared: 2/28/2024 12:49 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		16,503,449	0	16,503,449	418,830.62	39.40	1.00
2.00	Excluded area salaries (see instructions)		65,190	0	65,190	1,501.61	43.41	2.00
3.00	Subtotal salaries (line 1 minus line 2)		16,438,259	0	16,438,259	417,329.01	39.39	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,790,554	0	2,790,554	66,051.69	42.25	4.00
5.00	Subtotal wage-related costs (see inst.)		3,057,847	0	3,057,847	0.00	18.60	5.00
6.00	Total (sum of lines 3 thru 5)		22,286,660	0	22,286,660	483,380.70	46.11	6.00
7.00	Total overhead cost (see instructions)		4,422,831	0	4,422,831	135,202.00	32.71	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-3 Part IV Date/Time Prepared: 2/28/2024 12:49 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	38,456	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	1,232,112	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	149,652	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	1,731	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	-67,382	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	9,340	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,138,651	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	108,217	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2,610,777	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-3 Part V Date/Time Prepared: 2/28/2024 12:49 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	878,702	0	1.00
2.00	Hospital	878,702	0	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0184	Period: From 01/14/2023 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/28/2024 12:49 pm

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.117583	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,014,972	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	1,935,694	5.00
6.00	Medicaid charges	102,388,504	6.00
7.00	Medicaid cost (line 1 times line 6)	12,039,147	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	6,088,481	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	6,088,481	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	3,999,416	2,507	4,001,923	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	470,263	2,507	472,770	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 (see instructions)	470,263	2,507	472,770	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	0	26.00
27.00	Medicare reimbursable bad debts (see instructions)	0	27.00
27.01	Medicare allowable bad debts (see instructions)	0	27.01
28.00	Non-Medicare bad debt amount (see instructions)	0	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	0	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	472,770	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,561,251	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0184	Period: From 01/14/2023 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/28/2024 12:49 pm

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.117583	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		5.00
6.00	Medicaid charges		6.00
7.00	Medicaid cost (line 1 times line 6)		7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP		9.00
10.00	Stand-alone CHIP charges		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	3,999,416	2,507	4,001,923	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	470,263	2,507	472,770	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 (see instructions)	470,263	2,507	472,770	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	0	26.00
27.00	Medicare reimbursable bad debts (see instructions)	0	27.00
27.01	Medicare allowable bad debts (see instructions)	0	27.01
28.00	Non-Medicare bad debt amount (see instructions)	0	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	0	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	472,770	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	472,770	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/28/2024 12:49 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	7,828,705	7,828,705	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	2,172,062	2,172,062	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	265,615	85,816	351,431	1,696,432	2,047,863	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	973,931	29,553,099	30,527,030	-10,975,267	19,551,763	5.00
7.00	00700	OPERATION OF PLANT	388,061	2,138,205	2,526,266	-59,336	2,466,930	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	154,016	154,016	0	154,016	8.00
9.00	00900	HOUSEKEEPING	0	966,098	966,098	0	966,098	9.00
10.00	01000	DIETARY	0	1,128,798	1,128,798	-868,262	260,536	10.00
11.00	01100	CAFETERIA	0	0	0	868,262	868,262	11.00
13.00	01300	NURSING ADMINISTRATION	597,712	226,686	824,398	0	824,398	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	198,922	5,214,765	5,413,687	-4,411,065	1,002,622	14.00
15.00	01500	PHARMACY	874,167	1,605,690	2,479,857	-1,484,372	995,485	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	37,739	37,739	0	37,739	16.00
17.00	01700	SOCIAL SERVICE	275,018	23,281	298,299	0	298,299	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,967,914	2,739,901	4,707,815	-4,087	4,703,728	30.00
31.00	03100	INTENSIVE CARE UNIT	1,323,807	482,338	1,806,145	-22,213	1,783,932	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,167,358	2,991,611	5,158,969	-696,062	4,462,907	50.00
51.00	05100	RECOVERY ROOM	323,524	30,074	353,598	0	353,598	51.00
53.00	05300	ANESTHESIOLOGY	0	1,407,412	1,407,412	0	1,407,412	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	772,991	601,744	1,374,735	-205,503	1,169,232	54.00
56.00	05600	RADIOISOTOPE	153,208	213,806	367,014	-153,584	213,430	56.00
57.00	05700	CT SCAN	278,718	146,288	425,006	0	425,006	57.00
58.00	05800	MRI	109,017	76,335	185,352	0	185,352	58.00
59.00	05900	CARDIAC CATHETERIZATION	594,853	717,850	1,312,703	-250,955	1,061,748	59.00
60.00	06000	LABORATORY	1,094,313	1,719,438	2,813,751	-13,857	2,799,894	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	54,669	197,951	252,620	0	252,620	62.00
65.00	06500	RESPIRATORY THERAPY	507,554	294,895	802,449	-14,547	787,902	65.00
66.00	06600	PHYSICAL THERAPY	448,832	56,944	505,776	0	505,776	66.00
67.00	06700	OCCUPATIONAL THERAPY	111,455	8,763	120,218	0	120,218	67.00
68.00	06800	SPEECH PATHOLOGY	47,108	3,696	50,804	0	50,804	68.00
69.00	06900	ELECTROCARDIOLOGY	379,644	249,441	629,085	-21,182	607,903	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,386,629	1,386,629	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,417,859	3,417,859	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,508,872	1,508,872	73.00
74.00	07400	RENAL DIALYSIS	0	170,581	170,581	0	170,581	74.00
76.00	03020	INFUSION SERVICES	67,080	5,092	72,172	0	72,172	76.00
76.01	03610	SLEEP LAB	0	159,681	159,681	0	159,681	76.01
76.02	03030	PULMONARY REHAB	14,671	1,127	15,798	0	15,798	76.02
76.03	03951	WOUND CARE	34,616	4,331	38,947	0	38,947	76.03
76.97	07697	CARDIAC REHABILITATION	132,182	17,411	149,593	-2,955	146,638	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,650,884	1,173,277	2,824,161	-21,968	2,802,193	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	65,190	17,200	82,390	0	82,390	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,873,014	54,621,380	70,494,394	-326,394	70,168,000	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	2,094	2,094	0	2,094	192.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	326,394	326,394	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	15,873,014	54,623,474	70,496,488	0	70,496,488	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/28/2024 12:49 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	-4,259,130	3,569,575		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-947	2,171,115		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,303,904	3,351,767		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,509,404	11,042,359		5.00
7.00	00700	OPERATION OF PLANT	429,141	2,896,071		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	90,810	244,826		8.00
9.00	00900	HOUSEKEEPING	200,820	1,166,918		9.00
10.00	01000	DIETARY	115,112	375,648		10.00
11.00	01100	CAFETERIA	-117,756	750,506		11.00
13.00	01300	NURSING ADMINISTRATION	21,937	846,335		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	140,481	1,143,103		14.00
15.00	01500	PHARMACY	320,894	1,316,379		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,931	45,670		16.00
17.00	01700	SOCIAL SERVICE	252,808	551,107		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,896,965	2,806,763		30.00
31.00	03100	INTENSIVE CARE UNIT	-152,869	1,631,063		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-982,087	3,480,820		50.00
51.00	05100	RECOVERY ROOM	0	353,598		51.00
53.00	05300	ANESTHESIOLOGY	-1,337,383	70,029		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-20,643	1,148,589		54.00
56.00	05600	RADIOISOTOPE	0	213,430		56.00
57.00	05700	CT SCAN	0	425,006		57.00
58.00	05800	MRI	0	185,352		58.00
59.00	05900	CARDIAC CATHETERIZATION	-51,048	1,010,700		59.00
60.00	06000	LABORATORY	0	2,799,894		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	252,620		62.00
65.00	06500	RESPIRATORY THERAPY	0	787,902		65.00
66.00	06600	PHYSICAL THERAPY	0	505,776		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	120,218		67.00
68.00	06800	SPEECH PATHOLOGY	0	50,804		68.00
69.00	06900	ELECTROCARDIOLOGY	0	607,903		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,386,629		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,417,859		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,508,872		73.00
74.00	07400	RENAL DIALYSIS	0	170,581		74.00
76.00	03020	INFUSION SERVICES	0	72,172		76.00
76.01	03610	SLEEP LAB	-139,104	20,577		76.01
76.02	03030	PULMONARY REHAB	0	15,798		76.02
76.03	03951	WOUND CARE	0	38,947		76.03
76.97	07697	CARDIAC REHABILITATION	0	146,638		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-571,449	2,230,744		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	82,390		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-15,154,947	55,013,053		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	2,094		192.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0		194.00
194.01	07953	MARKETING	-155,401	170,993		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-15,310,348	55,186,140		200.00

RECLASSIFICATIONS | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/28/2024 12:49 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - BUILDING DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	58	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	58	
	B - EQUIPMENT DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,047,529	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	1,047,529	
	C - LEASES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	7,046,575	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	950,982	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	TOTALS		0	7,997,557	
	D - DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,508,872	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	1,508,872	
	E - SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,386,629	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,417,859	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	4,804,488	
	F - INSURANCE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	173,551	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	173,551	
	G - PROPERTY TAXES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	782,072	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	782,072	
	H - BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,696,432	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	1,696,432	
	I - CAFETERIA				
1.00	CAFETERIA	11.00	0	868,262	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	868,262	
	J - MARKETING				
1.00	MARKETING	194.01	0	326,394	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	326,394	
500.00	Grand Total: Increases		0	19,205,215	500.00

RECLASSIFICATIONS | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/28/2024 12:49 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - BUILDING DEPRECIATION						
1.00		0.00	0	0	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	58	0		2.00
	TOTALS		0	58			
	B - EQUIPMENT DEPRECIATION						
1.00		0.00	0	0	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,047,529	0		2.00
	TOTALS		0	1,047,529			
	C - LEASES						
1.00		0.00	0	0	10		1.00
2.00		0.00	0	0	10		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	6,949,231	0		3.00
4.00	OPERATION OF PLANT	7.00	0	59,336	0		4.00
5.00	PHARMACY	15.00	0	132,754	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	4,087	0		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	22,213	0		7.00
8.00	OPERATING ROOM	50.00	0	527,970	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	201,833	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	46,806	0		10.00
11.00	LABORATORY	60.00	0	13,857	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	14,547	0		12.00
13.00	CARDIAC REHABILITATION	76.97	0	2,955	0		13.00
14.00	EMERGENCY	91.00	0	21,968	0		14.00
	TOTALS		0	7,997,557			
	D - DRUGS						
1.00		0.00	0	0	0		1.00
2.00	PHARMACY	15.00	0	1,351,618	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,670	0		3.00
4.00	RADIOISOTOPE	56.00	0	153,584	0		4.00
	TOTALS		0	1,508,872			
	E - SUPPLIES						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	4,411,065	0		3.00
4.00	OPERATING ROOM	50.00	0	168,092	0		4.00
5.00	CARDIAC CATHETERIZATION	59.00	0	204,149	0		5.00
6.00	ELECTROCARDIOLOGY	69.00	0	21,182	0		6.00
	TOTALS		0	4,804,488			
	F - INSURANCE						
1.00		0.00	0	0	12		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	173,551	0		2.00
	TOTALS		0	173,551			
	G - PROPERTY TAXES						
1.00		0.00	0	0	13		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	782,072	0		2.00
	TOTALS		0	782,072			
	H - BENEFITS						
1.00		0.00	0	0	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,696,432	0		2.00
	TOTALS		0	1,696,432			
	I - CAFETERIA						
1.00		0.00	0	0	0		1.00
2.00	DIETARY	10.00	0	868,262	0		2.00
	TOTALS		0	868,262			
	J - MARKETING						
1.00		0.00	0	0	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	326,394	0		2.00
	TOTALS		0	326,394			
500.00	Grand Total: Decreases		0	19,205,215			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 2/28/2024 12:49 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	1,402,888	0	0	0	1,402,888	1.00
2.00	Land Improvements	822,554	0	0	0	822,554	2.00
3.00	Buildings and Fixtures	53,694,469	0	0	0	53,694,469	3.00
4.00	Building Improvements	28,375,492	0	0	0	28,375,492	4.00
5.00	Fixed Equipment	2,395,396	0	0	0	2,395,396	5.00
6.00	Movable Equipment	5,235,878	3,735,552	0	3,735,552	0	6.00
7.00	HIT designated Assets	6,012,893	0	0	0	6,012,893	7.00
8.00	Subtotal (sum of lines 1-7)	97,939,570	3,735,552	0	3,735,552	92,703,692	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	97,939,570	3,735,552	0	3,735,552	92,703,692	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	8,971,430	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	8,971,430	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	8,971,430	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 2/28/2024 12:49 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	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00

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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 2/28/2024 12:49 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	0	0	0	0.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,971,430	0	8,971,430	1.000000	0	2.00
3.00	Total (sum of lines 1-2)	8,971,430	0	8,971,430	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	58	2,787,445	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,046,582	950,982	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,046,640	3,738,427	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	782,072	0	3,569,575	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	173,551	0	0	2,171,115	2.00
3.00	Total (sum of lines 1-2)	0	173,551	782,072	0	5,740,690	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/28/2024 12:49 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)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	A	-423,028	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-16,246	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,158,491			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	-3,081,814			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-117,756	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)	B	0		0.00	0	19.00
20.00	Vending machines	B	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	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PROVIDER TAX	A	-5,321,861	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/28/2024 12:49 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	CHARITABLE CONTRIBUTIONS	A	-22,690	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	LOBBYING	A	-325	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	TELEPHONE SALARY ADJUSTMENT	A	-1,506	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	TELEPHONE BENEFIT ADJUSTMENT	A	-248	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	TELEPHONE DEPRECIATION	A	-709	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.05
33.06	TELEVISION DEPRECIATION	A	-238	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.06
33.07	TELEVISION UTILITY ADJUSTMENT	A	-10,035	OPERATION OF PLANT	7.00	0	33.07
33.08	MARKETING	A	-98,949	MARKETING	194.01	0	33.08
33.09	BUSINESS DEVELOPMENT	A	-56,452	MARKETING	194.01	0	33.09
33.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-15,310,348				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 2/28/2024 12:49 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	5.00	ADMINISTRATIVE & GENERAL	MEDICAL STAFFING	1,992,861	5,575,113	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	RENT	1,986,000	6,245,130	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1,433,565	129,413	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2,598,888	733,441	3.01
3.02	7.00	OPERATION OF PLANT	HOME OFFICE	472,206	33,030	3.02
3.03	8.00	LAUNDRY & LINEN SERVICE	HOME OFFICE	90,810	0	3.03
3.04	9.00	HOUSEKEEPING	HOME OFFICE	200,820	0	3.04
3.05	10.00	DIETARY	HOME OFFICE	115,112	0	3.05
3.06	13.00	NURSING ADMINISTRATION	HOME OFFICE	21,937	0	3.06
3.07	14.00	CENTRAL SERVICES & SUPPLY	HOME OFFICE	140,481	0	3.07
3.08	15.00	PHARMACY	HOME OFFICE	320,894	0	3.08
3.09	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	7,931	0	3.09
3.10	17.00	SOCIAL SERVICE	HOME OFFICE	259,164	6,356	3.10
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.			9,640,669	12,722,483	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	G		0.00	DEACONESS HEALT	0.00	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:	HOME OFFICE				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: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 2/28/2024 12:49 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	-3,582,252	0		1.00
2.00	-4,259,130	10		2.00
3.00	1,304,152	0		3.00
3.01	1,865,447	0		3.01
3.02	439,176	0		3.02
3.03	90,810	0		3.03
3.04	200,820	0		3.04
3.05	115,112	0		3.05
3.06	21,937	0		3.06
3.07	140,481	0		3.07
3.08	320,894	0		3.08
3.09	7,931	0		3.09
3.10	252,808	0		3.10
4.00	0	0		4.00
5.00	-3,081,814			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: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 2/28/2024 12:49 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	1,006,943	1,006,943	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	1,896,965	1,896,965	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	152,869	152,869	0	0	0	3.00
4.00	50.00	AGGREGATE-OPERATING ROOM	982,087	982,087	0	0	0	4.00
5.00	53.00	AGGREGATE-ANESTHESIOLOGY	1,337,383	1,337,383	0	0	0	5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	20,643	20,643	0	0	0	6.00
7.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	51,048	51,048	0	0	0	7.00
8.00	76.01	AGGREGATE-SLEEP LAB	139,104	139,104	0	0	0	8.00
9.00	91.00	AGGREGATE-EMERGENCY	571,449	571,449	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			6,158,491	6,158,491	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	0	0	0	0	0	7.00
8.00	76.01	AGGREGATE-SLEEP LAB	0	0	0	0	0	8.00
9.00	91.00	AGGREGATE-EMERGENCY	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	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	1,006,943		1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	1,896,965		2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	152,869		3.00
4.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	982,087		4.00
5.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	1,337,383		5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	20,643		6.00
7.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	0	0	0	51,048		7.00
8.00	76.01	AGGREGATE-SLEEP LAB	0	0	0	139,104		8.00
9.00	91.00	AGGREGATE-EMERGENCY	0	0	0	571,449		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	6,158,491		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/28/2024 12:49 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,569,575	3,569,575				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,171,115		2,171,115			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,351,767	19,557	11,895	3,383,219		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,042,359	386,032	234,795	211,119	11,874,305	5.00
7.00	00700	OPERATION OF PLANT	2,896,071	828,143	503,699	84,120	4,312,033	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	244,826	8,030	4,884	0	257,740	8.00
9.00	00900	HOUSEKEEPING	1,166,918	21,774	13,244	0	1,201,936	9.00
10.00	01000	DIETARY	375,648	59,333	36,088	0	471,069	10.00
11.00	01100	CAFETERIA	750,506	67,056	40,785	0	858,347	11.00
13.00	01300	NURSING ADMINISTRATION	846,335	92,440	56,225	129,566	1,124,566	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,143,103	37,737	22,953	43,120	1,246,913	14.00
15.00	01500	PHARMACY	1,316,379	33,366	20,294	189,493	1,559,532	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	45,670	55,529	33,774	0	134,973	16.00
17.00	01700	SOCIAL SERVICE	551,107	0	0	59,616	610,723	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,806,763	441,868	268,757	426,585	3,943,973	30.00
31.00	03100	INTENSIVE CARE UNIT	1,631,063	198,221	120,563	286,962	2,236,809	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,480,820	318,846	193,931	469,822	4,463,419	50.00
51.00	05100	RECOVERY ROOM	353,598	13,502	8,212	70,130	445,442	51.00
53.00	05300	ANESTHESIOLOGY	70,029	4,598	2,796	0	77,423	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,148,589	151,790	92,323	167,561	1,560,263	54.00
56.00	05600	RADIOISOTOPE	213,430	11,187	6,804	33,211	264,632	56.00
57.00	05700	CT SCAN	425,006	19,459	11,836	60,418	516,719	57.00
58.00	05800	MRI	185,352	20,674	12,574	23,632	242,232	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,010,700	35,956	21,870	128,946	1,197,472	59.00
60.00	06000	LABORATORY	2,799,894	76,704	46,654	237,214	3,160,466	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	252,620	4,080	2,481	11,851	271,032	62.00
65.00	06500	RESPIRATORY THERAPY	787,902	17,565	10,684	110,022	926,173	65.00
66.00	06600	PHYSICAL THERAPY	505,776	105,958	64,447	97,293	773,474	66.00
67.00	06700	OCCUPATIONAL THERAPY	120,218	2,671	1,625	24,160	148,674	67.00
68.00	06800	SPEECH PATHOLOGY	50,804	1,506	916	10,212	63,438	68.00
69.00	06900	ELECTROCARDIOLOGY	607,903	67,833	41,258	82,295	799,289	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,386,629	0	0	0	1,386,629	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,417,859	0	0	0	3,417,859	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,508,872	0	0	0	1,508,872	73.00
74.00	07400	RENAL DIALYSIS	170,581	5,407	3,289	0	179,277	74.00
76.00	03020	INFUSION SERVICES	72,172	0	0	14,541	86,713	76.00
76.01	03610	SLEEP LAB	20,577	38,142	23,199	0	81,918	76.01
76.02	03030	PULMONARY REHAB	15,798	0	0	3,180	18,978	76.02
76.03	03951	WOUND CARE	38,947	45,556	27,709	7,504	119,716	76.03
76.97	07697	CARDIAC REHABILITATION	146,638	0	0	28,653	175,291	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,230,744	154,413	93,918	357,862	2,836,937	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	82,390	0	0	14,131	96,521	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	55,013,053	3,344,933	2,034,482	3,383,219	54,651,778	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	10,944	6,656	0	17,600	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,094	213,698	129,977	0	345,769	192.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	170,993	0	0	0	170,993	194.01
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)	55,186,140	3,569,575	2,171,115	3,383,219	55,186,140	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/28/2024 12:49 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,874,305					5.00
7.00	00700	OPERATION OF PLANT	1,182,178	5,494,211				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	70,661	18,887	347,288			8.00
9.00	00900	HOUSEKEEPING	329,520	51,216	0	1,582,672		9.00
10.00	01000	DIETARY	129,147	139,560	0	40,722	780,498	10.00
11.00	01100	CAFETERIA	235,323	157,724	0	46,021	0	11.00
13.00	01300	NURSING ADMINISTRATION	308,309	217,432	0	63,443	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	341,851	88,762	0	25,900	0	14.00
15.00	01500	PHARMACY	427,558	78,481	0	22,900	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	37,004	130,611	0	38,110	0	16.00
17.00	01700	SOCIAL SERVICE	167,435	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,081,272	1,039,333	83,054	303,262	650,231	30.00
31.00	03100	INTENSIVE CARE UNIT	613,239	466,241	39,537	136,042	67,884	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,223,704	749,969	42,731	218,829	0	50.00
51.00	05100	RECOVERY ROOM	122,121	31,758	0	9,267	0	51.00
53.00	05300	ANESTHESIOLOGY	21,226	10,814	0	3,155	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	427,759	357,030	35,862	104,176	0	54.00
56.00	05600	RADIOISOTOPE	72,551	26,313	0	7,678	0	56.00
57.00	05700	CT SCAN	141,663	45,771	0	13,355	0	57.00
58.00	05800	MRI	66,410	48,627	0	14,189	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	328,297	84,574	0	24,677	0	59.00
60.00	06000	LABORATORY	866,467	180,419	0	52,644	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	74,306	9,596	0	2,800	0	62.00
65.00	06500	RESPIRATORY THERAPY	253,918	41,316	0	12,055	0	65.00
66.00	06600	PHYSICAL THERAPY	212,054	249,228	23,014	72,721	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	40,760	6,283	0	1,833	0	67.00
68.00	06800	SPEECH PATHOLOGY	17,392	3,541	0	1,033	0	68.00
69.00	06900	ELECTROCARDIOLOGY	219,131	159,552	25,825	46,555	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	380,155	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	937,033	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	413,669	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	49,150	12,718	76	3,711	0	74.00
76.00	03020	INFUSION SERVICES	23,773	0	0	0	0	76.00
76.01	03610	SLEEP LAB	22,458	89,714	868	26,177	0	76.01
76.02	03030	PULMONARY REHAB	5,203	0	0	0	0	76.02
76.03	03951	WOUND CARE	32,821	107,155	0	31,266	0	76.03
76.97	07697	CARDIAC REHABILITATION	48,057	0	3,564	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	777,769	363,199	89,997	105,976	62,383	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	26,462	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,727,806	4,965,824	344,528	1,428,497	780,498	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	4,825	25,742	0	7,511	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	94,795	502,645	2,760	146,664	0	192.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	46,879	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,874,305	5,494,211	347,288	1,582,672	780,498	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/28/2024 12:49 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,297,415					11.00
13.00	01300	NURSING ADMINISTRATION	41,537	1,755,287				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	34,207	0	1,737,633			14.00
15.00	01500	PHARMACY	68,414	0	16,409	2,173,294		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	357	0	341,055	16.00
17.00	01700	SOCIAL SERVICE	18,732	0	59	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	201,983	347,770	41,284	0	21,094	30.00
31.00	03100	INTENSIVE CARE UNIT	99,363	345,652	45,972	0	3,261	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	192,210	398,836	153,328	0	42,529	50.00
51.00	05100	RECOVERY ROOM	21,176	106,980	992	0	8,328	51.00
53.00	05300	ANESTHESIOLOGY	0	0	16,753	0	9,671	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	74,115	11,986	6,617	0	12,251	54.00
56.00	05600	RADIOISOTOPE	11,402	0	828	0	6,448	56.00
57.00	05700	CT SCAN	29,320	0	10,403	0	29,980	57.00
58.00	05800	MRI	8,144	0	301	0	4,441	58.00
59.00	05900	CARDIAC CATHETERIZATION	45,609	87,169	2,234	0	31,950	59.00
60.00	06000	LABORATORY	140,899	0	131,716	0	55,355	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,701	0	0	0	464	62.00
65.00	06500	RESPIRATORY THERAPY	45,609	0	16,376	0	7,952	65.00
66.00	06600	PHYSICAL THERAPY	45,609	0	2,396	0	5,390	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,588	0	0	0	1,509	67.00
68.00	06800	SPEECH PATHOLOGY	4,072	0	0	0	345	68.00
69.00	06900	ELECTROCARDIOLOGY	45,609	2,531	919	0	14,848	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	349,618	0	7,225	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	861,764	0	23,381	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,173,294	15,554	73.00
74.00	07400	RENAL DIALYSIS	0	0	560	0	799	74.00
76.00	03020	INFUSION SERVICES	5,701	19,135	0	0	462	76.00
76.01	03610	SLEEP LAB	0	0	690	0	565	76.01
76.02	03030	PULMONARY REHAB	1,629	0	0	0	613	76.02
76.03	03951	WOUND CARE	3,258	0	121	0	1	76.03
76.97	07697	CARDIAC REHABILITATION	13,031	28,029	628	0	556	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	123,796	407,199	77,308	0	36,083	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,701	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,297,415	1,755,287	1,737,633	2,173,294	341,055	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,297,415	1,755,287	1,737,633	2,173,294	341,055	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/28/2024 12:49 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	796,949					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	699,681	8,412,937	0	8,412,937		30.00
31.00	03100	INTENSIVE CARE UNIT	97,268	4,151,268	0	4,151,268		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,485,555	0	7,485,555		50.00
51.00	05100	RECOVERY ROOM	0	746,064	0	746,064		51.00
53.00	05300	ANESTHESIOLOGY	0	139,042	0	139,042		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,590,059	0	2,590,059		54.00
56.00	05600	RADIOISOTOPE	0	389,852	0	389,852		56.00
57.00	05700	CT SCAN	0	787,211	0	787,211		57.00
58.00	05800	MRI	0	384,344	0	384,344		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,801,982	0	1,801,982		59.00
60.00	06000	LABORATORY	0	4,587,966	0	4,587,966		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	363,899	0	363,899		62.00
65.00	06500	RESPIRATORY THERAPY	0	1,303,399	0	1,303,399		65.00
66.00	06600	PHYSICAL THERAPY	0	1,383,886	0	1,383,886		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	209,647	0	209,647		67.00
68.00	06800	SPEECH PATHOLOGY	0	89,821	0	89,821		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,314,259	0	1,314,259		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,123,627	0	2,123,627		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,240,037	0	5,240,037		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,111,389	0	4,111,389		73.00
74.00	07400	RENAL DIALYSIS	0	246,291	0	246,291		74.00
76.00	03020	INFUSION SERVICES	0	135,784	0	135,784		76.00
76.01	03610	SLEEP LAB	0	222,390	0	222,390		76.01
76.02	03030	PULMONARY REHAB	0	26,423	0	26,423		76.02
76.03	03951	WOUND CARE	0	294,338	0	294,338		76.03
76.97	07697	CARDIAC REHABILITATION	0	269,156	0	269,156		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	4,880,647	0	4,880,647		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	128,684	0	128,684		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	796,949	53,819,957	0	53,819,957		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	55,678	0	55,678		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	1,092,633	0	1,092,633		192.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0		194.00
194.01	07953	MARKETING	0	217,872	0	217,872		194.01
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	796,949	55,186,140	0	55,186,140		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/28/2024 12:49 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	19,557	11,895	31,452	31,452	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	386,032	234,795	620,827	1,962	5.00
7.00	00700	OPERATION OF PLANT	0	828,143	503,699	1,331,842	782	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,030	4,884	12,914	0	8.00
9.00	00900	HOUSEKEEPING	0	21,774	13,244	35,018	0	9.00
10.00	01000	DIETARY	0	59,333	36,088	95,421	0	10.00
11.00	01100	CAFETERIA	0	67,056	40,785	107,841	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	92,440	56,225	148,665	1,204	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	37,737	22,953	60,690	401	14.00
15.00	01500	PHARMACY	0	33,366	20,294	53,660	1,761	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	55,529	33,774	89,303	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	554	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	441,868	268,757	710,625	3,965	30.00
31.00	03100	INTENSIVE CARE UNIT	0	198,221	120,563	318,784	2,667	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	318,846	193,931	512,777	4,370	50.00
51.00	05100	RECOVERY ROOM	0	13,502	8,212	21,714	652	51.00
53.00	05300	ANESTHESIOLOGY	0	4,598	2,796	7,394	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	151,790	92,323	244,113	1,558	54.00
56.00	05600	RADIOISOTOPE	0	11,187	6,804	17,991	309	56.00
57.00	05700	CT SCAN	0	19,459	11,836	31,295	562	57.00
58.00	05800	MRI	0	20,674	12,574	33,248	220	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	35,956	21,870	57,826	1,199	59.00
60.00	06000	LABORATORY	0	76,704	46,654	123,358	2,205	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,080	2,481	6,561	110	62.00
65.00	06500	RESPIRATORY THERAPY	0	17,565	10,684	28,249	1,023	65.00
66.00	06600	PHYSICAL THERAPY	0	105,958	64,447	170,405	904	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,671	1,625	4,296	225	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,506	916	2,422	95	68.00
69.00	06900	ELECTROCARDIOLOGY	0	67,833	41,258	109,091	765	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	5,407	3,289	8,696	0	74.00
76.00	03020	INFUSION SERVICES	0	0	0	0	135	76.00
76.01	03610	SLEEP LAB	0	38,142	23,199	61,341	0	76.01
76.02	03030	PULMONARY REHAB	0	0	0	0	30	76.02
76.03	03951	WOUND CARE	0	45,556	27,709	73,265	70	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	266	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	154,413	93,918	248,331	3,327	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	131	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,344,933	2,034,482	5,379,415	31,452	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	10,944	6,656	17,600	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	213,698	129,977	343,675	0	192.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,569,575	2,171,115	5,740,690	31,452	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/28/2024 12:49 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	622,789					5.00
7.00	00700	OPERATION OF PLANT	62,003	1,394,627				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,706	4,794	21,414			8.00
9.00	00900	HOUSEKEEPING	17,283	13,001	0	65,302		9.00
10.00	01000	DIETARY	6,774	35,425	0	1,680	139,300	10.00
11.00	01100	CAFETERIA	12,342	40,036	0	1,899	0	11.00
13.00	01300	NURSING ADMINISTRATION	16,170	55,192	0	2,618	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17,929	22,531	0	1,069	0	14.00
15.00	01500	PHARMACY	22,425	19,921	0	945	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,941	33,154	0	1,572	0	16.00
17.00	01700	SOCIAL SERVICE	8,782	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	56,710	263,820	5,121	12,513	116,050	30.00
31.00	03100	INTENSIVE CARE UNIT	32,163	118,349	2,438	5,613	12,116	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	64,188	190,369	2,635	9,029	0	50.00
51.00	05100	RECOVERY ROOM	6,405	8,061	0	382	0	51.00
53.00	05300	ANESTHESIOLOGY	1,113	2,745	0	130	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,435	90,627	2,211	4,298	0	54.00
56.00	05600	RADIOISOTOPE	3,805	6,679	0	317	0	56.00
57.00	05700	CT SCAN	7,430	11,618	0	551	0	57.00
58.00	05800	MRI	3,483	12,343	0	585	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	17,218	21,468	0	1,018	0	59.00
60.00	06000	LABORATORY	45,444	45,797	0	2,172	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,897	2,436	0	116	0	62.00
65.00	06500	RESPIRATORY THERAPY	13,317	10,487	0	497	0	65.00
66.00	06600	PHYSICAL THERAPY	11,122	63,263	1,419	3,001	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,138	1,595	0	76	0	67.00
68.00	06800	SPEECH PATHOLOGY	912	899	0	43	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,493	40,500	1,592	1,921	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,938	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,145	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,696	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,578	3,228	5	153	0	74.00
76.00	03020	INFUSION SERVICES	1,247	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,178	22,773	54	1,080	0	76.01
76.02	03030	PULMONARY REHAB	273	0	0	0	0	76.02
76.03	03951	WOUND CARE	1,721	27,200	0	1,290	0	76.03
76.97	07697	CARDIAC REHABILITATION	2,521	0	220	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	40,792	92,193	5,549	4,373	11,134	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,388	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	615,105	1,260,504	21,244	58,941	139,300	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	253	6,534	0	310	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	4,972	127,589	170	6,051	0	192.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	2,459	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	622,789	1,394,627	21,414	65,302	139,300	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/28/2024 12:49 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	162,118					11.00
13.00	01300	NURSING ADMINISTRATION	5,190	229,039				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,274	0	106,894			14.00
15.00	01500	PHARMACY	8,549	0	1,009	108,270		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	22	0	125,992	16.00
17.00	01700	SOCIAL SERVICE	2,341	0	4	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,239	45,379	2,540	0	7,786	30.00
31.00	03100	INTENSIVE CARE UNIT	12,416	45,102	2,828	0	1,204	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,017	52,042	9,433	0	15,699	50.00
51.00	05100	RECOVERY ROOM	2,646	13,959	61	0	3,074	51.00
53.00	05300	ANESTHESIOLOGY	0	0	1,031	0	3,570	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,261	1,564	407	0	4,522	54.00
56.00	05600	RADIOISOTOPE	1,425	0	51	0	2,380	56.00
57.00	05700	CT SCAN	3,664	0	640	0	11,067	57.00
58.00	05800	MRI	1,018	0	19	0	1,639	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,699	11,374	137	0	11,794	59.00
60.00	06000	LABORATORY	17,606	0	8,103	0	20,531	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	712	0	0	0	171	62.00
65.00	06500	RESPIRATORY THERAPY	5,699	0	1,007	0	2,935	65.00
66.00	06600	PHYSICAL THERAPY	5,699	0	147	0	1,990	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,323	0	0	0	557	67.00
68.00	06800	SPEECH PATHOLOGY	509	0	0	0	127	68.00
69.00	06900	ELECTROCARDIOLOGY	5,699	330	57	0	5,481	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	21,508	0	2,667	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	53,012	0	8,631	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	108,270	5,742	73.00
74.00	07400	RENAL DIALYSIS	0	0	34	0	295	74.00
76.00	03020	INFUSION SERVICES	712	2,497	0	0	171	76.00
76.01	03610	SLEEP LAB	0	0	42	0	209	76.01
76.02	03030	PULMONARY REHAB	204	0	0	0	226	76.02
76.03	03951	WOUND CARE	407	0	7	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	1,628	3,657	39	0	205	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	15,469	53,135	4,756	0	13,319	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	712	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	162,118	229,039	106,894	108,270	125,992	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	162,118	229,039	106,894	108,270	125,992	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/28/2024 12:49 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	11,681					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,255	1,260,003	0	1,260,003		30.00
31.00	03100	INTENSIVE CARE UNIT	1,426	555,106	0	555,106		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	884,559	0	884,559		50.00
51.00	05100	RECOVERY ROOM	0	56,954	0	56,954		51.00
53.00	05300	ANESTHESIOLOGY	0	15,983	0	15,983		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	380,996	0	380,996		54.00
56.00	05600	RADIOISOTOPE	0	32,957	0	32,957		56.00
57.00	05700	CT SCAN	0	66,827	0	66,827		57.00
58.00	05800	MRI	0	52,555	0	52,555		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	127,733	0	127,733		59.00
60.00	06000	LABORATORY	0	265,216	0	265,216		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	14,003	0	14,003		62.00
65.00	06500	RESPIRATORY THERAPY	0	63,214	0	63,214		65.00
66.00	06600	PHYSICAL THERAPY	0	257,950	0	257,950		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,210	0	10,210		67.00
68.00	06800	SPEECH PATHOLOGY	0	5,007	0	5,007		68.00
69.00	06900	ELECTROCARDIOLOGY	0	176,929	0	176,929		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	44,113	0	44,113		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	110,788	0	110,788		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	135,708	0	135,708		73.00
74.00	07400	RENAL DIALYSIS	0	14,989	0	14,989		74.00
76.00	03020	INFUSION SERVICES	0	4,762	0	4,762		76.00
76.01	03610	SLEEP LAB	0	86,677	0	86,677		76.01
76.02	03030	PULMONARY REHAB	0	733	0	733		76.02
76.03	03951	WOUND CARE	0	103,960	0	103,960		76.03
76.97	07697	CARDIAC REHABILITATION	0	8,536	0	8,536		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	492,378	0	492,378		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,231	0	2,231		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,681	5,231,077	0	5,231,077		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	24,697	0	24,697		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	482,457	0	482,457		192.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0		194.00
194.01	07953	MARKETING	0	2,459	0	2,459		194.01
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	11,681	5,740,690	0	5,740,690		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/28/2024 12:49 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	220,491					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		220,491				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,208	1,208	15,607,399			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,845	23,845	973,931	-11,874,305	43,311,835	5.00
7.00	00700	OPERATION OF PLANT	51,154	51,154	388,061	0	4,312,033	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	496	496	0	0	257,740	8.00
9.00	00900	HOUSEKEEPING	1,345	1,345	0	0	1,201,936	9.00
10.00	01000	DIETARY	3,665	3,665	0	0	471,069	10.00
11.00	01100	CAFETERIA	4,142	4,142	0	0	858,347	11.00
13.00	01300	NURSING ADMINISTRATION	5,710	5,710	597,712	0	1,124,566	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,331	2,331	198,922	0	1,246,913	14.00
15.00	01500	PHARMACY	2,061	2,061	874,167	0	1,559,532	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,430	3,430	0	0	134,973	16.00
17.00	01700	SOCIAL SERVICE	0	0	275,018	0	610,723	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,294	27,294	1,967,914	0	3,943,973	30.00
31.00	03100	INTENSIVE CARE UNIT	12,244	12,244	1,323,807	0	2,236,809	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,695	19,695	2,167,358	0	4,463,419	50.00
51.00	05100	RECOVERY ROOM	834	834	323,524	0	445,442	51.00
53.00	05300	ANESTHESIOLOGY	284	284	0	0	77,423	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,376	9,376	772,991	0	1,560,263	54.00
56.00	05600	RADIOISOTOPE	691	691	153,208	0	264,632	56.00
57.00	05700	CT SCAN	1,202	1,202	278,718	0	516,719	57.00
58.00	05800	MRI	1,277	1,277	109,017	0	242,232	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,221	2,221	594,853	0	1,197,472	59.00
60.00	06000	LABORATORY	4,738	4,738	1,094,313	0	3,160,466	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	252	252	54,669	0	271,032	62.00
65.00	06500	RESPIRATORY THERAPY	1,085	1,085	507,554	0	926,173	65.00
66.00	06600	PHYSICAL THERAPY	6,545	6,545	448,832	0	773,474	66.00
67.00	06700	OCCUPATIONAL THERAPY	165	165	111,455	0	148,674	67.00
68.00	06800	SPEECH PATHOLOGY	93	93	47,108	0	63,438	68.00
69.00	06900	ELECTROCARDIOLOGY	4,190	4,190	379,644	0	799,289	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,386,629	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,417,859	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,508,872	73.00
74.00	07400	RENAL DIALYSIS	334	334	0	0	179,277	74.00
76.00	03020	INFUSION SERVICES	0	0	67,080	0	86,713	76.00
76.01	03610	SLEEP LAB	2,356	2,356	0	0	81,918	76.01
76.02	03030	PULMONARY REHAB	0	0	14,671	0	18,978	76.02
76.03	03951	WOUND CARE	2,814	2,814	34,616	0	119,716	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	132,182	0	175,291	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	9,538	9,538	1,650,884	0	2,836,937	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	65,190	0	96,521	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	206,615	206,615	15,607,399	-11,874,305	42,777,473	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	676	676	0	0	17,600	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	13,200	13,200	0	0	345,769	192.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	0	170,993	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,569,575	2,171,115	3,383,219		11,874,305	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.189210	9.846728	0.216770		0.274158	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			31,452		622,789	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002015		0.014379	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/28/2024 12:49 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	144,284					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	496	227,728				8.00
9.00	00900	HOUSEKEEPING	1,345	0	142,443			9.00
10.00	01000	DIETARY	3,665	0	3,665	19,155		10.00
11.00	01100	CAFETERIA	4,142	0	4,142	0	1,593	11.00
13.00	01300	NURSING ADMINISTRATION	5,710	0	5,710	0	51	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,331	0	2,331	0	42	14.00
15.00	01500	PHARMACY	2,061	0	2,061	0	84	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,430	0	3,430	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	23	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,294	54,461	27,294	15,958	248	30.00
31.00	03100	INTENSIVE CARE UNIT	12,244	25,926	12,244	1,666	122	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,695	28,020	19,695	0	236	50.00
51.00	05100	RECOVERY ROOM	834	0	834	0	26	51.00
53.00	05300	ANESTHESIOLOGY	284	0	284	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,376	23,516	9,376	0	91	54.00
56.00	05600	RADIOISOTOPE	691	0	691	0	14	56.00
57.00	05700	CT SCAN	1,202	0	1,202	0	36	57.00
58.00	05800	MRI	1,277	0	1,277	0	10	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,221	0	2,221	0	56	59.00
60.00	06000	LABORATORY	4,738	0	4,738	0	173	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	252	0	252	0	7	62.00
65.00	06500	RESPIRATORY THERAPY	1,085	0	1,085	0	56	65.00
66.00	06600	PHYSICAL THERAPY	6,545	15,091	6,545	0	56	66.00
67.00	06700	OCCUPATIONAL THERAPY	165	0	165	0	13	67.00
68.00	06800	SPEECH PATHOLOGY	93	0	93	0	5	68.00
69.00	06900	ELECTROCARDIOLOGY	4,190	16,934	4,190	0	56	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	334	50	334	0	0	74.00
76.00	03020	INFUSION SERVICES	0	0	0	0	7	76.00
76.01	03610	SLEEP LAB	2,356	569	2,356	0	0	76.01
76.02	03030	PULMONARY REHAB	0	0	0	0	2	76.02
76.03	03951	WOUND CARE	2,814	0	2,814	0	4	76.03
76.97	07697	CARDIAC REHABILITATION	0	2,337	0	0	16	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	9,538	59,014	9,538	1,531	152	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	7	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	130,408	225,918	128,567	19,155	1,593	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	676	0	676	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	13,200	1,810	13,200	0	0	192.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,494,211	347,288	1,582,672	780,498	1,297,415	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	38.079143	1.525012	11.110915	40.746437	814.447583	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,394,627	21,414	65,302	139,300	162,118	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	9.665847	0.094033	0.458443	7.272253	101.768989	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/28/2024 12:49 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,600,093					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,891,668				14.00
15.00	01500	PHARMACY	0	65,079	1,508,872			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,414	0	457,749,769		16.00
17.00	01700	SOCIAL SERVICE	0	233	0	0	5,678	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	317,022	163,739	0	28,313,980	4,985	30.00
31.00	03100	INTENSIVE CARE UNIT	315,091	182,332	0	4,376,759	693	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	363,573	608,117	0	57,085,492	0	50.00
51.00	05100	RECOVERY ROOM	97,521	3,935	0	11,178,855	0	51.00
53.00	05300	ANESTHESIOLOGY	0	66,445	0	12,981,340	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,926	26,242	0	16,444,601	0	54.00
56.00	05600	RADIOISOTOPE	0	3,285	0	8,655,566	0	56.00
57.00	05700	CT SCAN	0	41,259	0	40,241,921	0	57.00
58.00	05800	MRI	0	1,193	0	5,960,796	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	79,462	8,860	0	42,886,422	0	59.00
60.00	06000	LABORATORY	0	522,403	0	74,257,337	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	622,226	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	64,950	0	10,674,037	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,501	0	7,235,079	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,025,781	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	462,862	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,307	3,645	0	19,929,823	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,386,629	0	9,697,878	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,417,859	0	31,384,180	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,508,872	20,878,479	0	73.00
74.00	07400	RENAL DIALYSIS	0	2,223	0	1,072,236	0	74.00
76.00	03020	INFUSION SERVICES	17,443	0	0	620,509	0	76.00
76.01	03610	SLEEP LAB	0	2,737	0	759,031	0	76.01
76.02	03030	PULMONARY REHAB	0	0	0	823,391	0	76.02
76.03	03951	WOUND CARE	0	481	0	1,109	0	76.03
76.97	07697	CARDIAC REHABILITATION	25,551	2,492	0	746,018	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	371,197	306,615	0	48,434,061	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,600,093	6,891,668	1,508,872	457,749,769	5,678	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,755,287	1,737,633	2,173,294	341,055	796,949	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.096991	0.252135	1.440344	0.000745	140.357344	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	229,039	106,894	108,270	125,992	11,681	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.143141	0.015511	0.071756	0.000275	2.057238	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/28/2024 12:49 pm

Title XVIII | Hospital | PPS

		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	8,412,937		8,412,937	0	8,412,937	30.00
31.00	03100	INTENSIVE CARE UNIT	4,151,268		4,151,268	0	4,151,268	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,485,555		7,485,555	0	7,485,555	50.00
51.00	05100	RECOVERY ROOM	746,064		746,064	0	746,064	51.00
53.00	05300	ANESTHESIOLOGY	139,042		139,042	0	139,042	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,590,059		2,590,059	0	2,590,059	54.00
56.00	05600	RADIOISOTOPE	389,852		389,852	0	389,852	56.00
57.00	05700	CT SCAN	787,211		787,211	0	787,211	57.00
58.00	05800	MRI	384,344		384,344	0	384,344	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,801,982		1,801,982	0	1,801,982	59.00
60.00	06000	LABORATORY	4,587,966		4,587,966	0	4,587,966	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	363,899		363,899	0	363,899	62.00
65.00	06500	RESPIRATORY THERAPY	1,303,399	0	1,303,399	0	1,303,399	65.00
66.00	06600	PHYSICAL THERAPY	1,383,886	0	1,383,886	0	1,383,886	66.00
67.00	06700	OCCUPATIONAL THERAPY	209,647	0	209,647	0	209,647	67.00
68.00	06800	SPEECH PATHOLOGY	89,821	0	89,821	0	89,821	68.00
69.00	06900	ELECTROCARDIOLOGY	1,314,259		1,314,259	0	1,314,259	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,123,627		2,123,627	0	2,123,627	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,240,037		5,240,037	0	5,240,037	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,111,389		4,111,389	0	4,111,389	73.00
74.00	07400	RENAL DIALYSIS	246,291		246,291	0	246,291	74.00
76.00	03020	INFUSION SERVICES	135,784		135,784	0	135,784	76.00
76.01	03610	SLEEP LAB	222,390		222,390	0	222,390	76.01
76.02	03030	PULMONARY REHAB	26,423		26,423	0	26,423	76.02
76.03	03951	WOUND CARE	294,338		294,338	0	294,338	76.03
76.97	07697	CARDIAC REHABILITATION	269,156		269,156	0	269,156	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,880,647		4,880,647	0	4,880,647	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,008,158		2,008,158		2,008,158	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	128,684		128,684	0	128,684	95.00
200.00		Subtotal (see instructions)	55,828,115	0	55,828,115	0	55,828,115	200.00
201.00		Less Observation Beds	2,008,158		2,008,158		2,008,158	201.00
202.00		Total (see instructions)	53,819,957	0	53,819,957	0	53,819,957	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/28/2024 12:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,424,343		24,424,343			30.00
31.00	03100	INTENSIVE CARE UNIT	4,370,444		4,370,444			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,688,575	45,396,917	57,085,492	0.131129	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,182,209	7,996,647	11,178,856	0.066739	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	3,882,917	9,098,423	12,981,340	0.010711	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,915,441	13,529,160	16,444,601	0.157502	0.000000	54.00
56.00	05600	RADIOISOTOPE	2,162,621	6,492,945	8,655,566	0.045041	0.000000	56.00
57.00	05700	CT SCAN	8,213,151	32,028,770	40,241,921	0.019562	0.000000	57.00
58.00	05800	MRI	514,034	5,446,763	5,960,797	0.064479	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	23,461,160	19,425,262	42,886,422	0.042018	0.000000	59.00
60.00	06000	LABORATORY	17,506,320	56,751,017	74,257,337	0.061785	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	463,247	158,980	622,227	0.584833	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	9,954,228	719,809	10,674,037	0.122109	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,354,400	3,880,679	7,235,079	0.191274	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,487,607	538,174	2,025,781	0.103489	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	262,930	199,932	462,862	0.194056	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	8,805,100	11,124,723	19,929,823	0.065944	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,806,337	3,891,541	9,697,878	0.218979	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,639,233	19,744,947	31,384,180	0.166964	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,206,365	9,672,115	20,878,480	0.196920	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,025,201	47,035	1,072,236	0.229698	0.000000	74.00
76.00	03020	INFUSION SERVICES	152,795	467,713	620,508	0.218827	0.000000	76.00
76.01	03610	SLEEP LAB	0	759,031	759,031	0.292992	0.000000	76.01
76.02	03030	PULMONARY REHAB	0	823,391	823,391	0.032090	0.000000	76.02
76.03	03951	WOUND CARE	1,109	0	1,109	265.408476	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	746,018	746,018	0.360790	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,597,640	39,836,420	48,434,060	0.100769	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,267,410	2,599,524	3,866,934	0.519315	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	166,344,817	291,375,936	457,720,753			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	166,344,817	291,375,936	457,720,753			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/28/2024 12:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.131129		50.00
51.00	05100	RECOVERY ROOM	0.066739		51.00
53.00	05300	ANESTHESIOLOGY	0.010711		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.157502		54.00
56.00	05600	RADIOISOTOPE	0.045041		56.00
57.00	05700	CT SCAN	0.019562		57.00
58.00	05800	MRI	0.064479		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.042018		59.00
60.00	06000	LABORATORY	0.061785		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.584833		62.00
65.00	06500	RESPIRATORY THERAPY	0.122109		65.00
66.00	06600	PHYSICAL THERAPY	0.191274		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.103489		67.00
68.00	06800	SPEECH PATHOLOGY	0.194056		68.00
69.00	06900	ELECTROCARDIOLOGY	0.065944		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.218979		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.166964		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196920		73.00
74.00	07400	RENAL DIALYSIS	0.229698		74.00
76.00	03020	INFUSION SERVICES	0.218827		76.00
76.01	03610	SLEEP LAB	0.292992		76.01
76.02	03030	PULMONARY REHAB	0.032090		76.02
76.03	03951	WOUND CARE	265.408476		76.03
76.97	07697	CARDIAC REHABILITATION	0.360790		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.100769		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.519315		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/28/2024 12:49 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	8,412,937		8,412,937	0	8,412,937	30.00
31.00	03100	INTENSIVE CARE UNIT	4,151,268		4,151,268	0	4,151,268	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,485,555		7,485,555	0	7,485,555	50.00
51.00	05100	RECOVERY ROOM	746,064		746,064	0	746,064	51.00
53.00	05300	ANESTHESIOLOGY	139,042		139,042	0	139,042	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,590,059		2,590,059	0	2,590,059	54.00
56.00	05600	RADIOISOTOPE	389,852		389,852	0	389,852	56.00
57.00	05700	CT SCAN	787,211		787,211	0	787,211	57.00
58.00	05800	MRI	384,344		384,344	0	384,344	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,801,982		1,801,982	0	1,801,982	59.00
60.00	06000	LABORATORY	4,587,966		4,587,966	0	4,587,966	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	363,899		363,899	0	363,899	62.00
65.00	06500	RESPIRATORY THERAPY	1,303,399	0	1,303,399	0	1,303,399	65.00
66.00	06600	PHYSICAL THERAPY	1,383,886	0	1,383,886	0	1,383,886	66.00
67.00	06700	OCCUPATIONAL THERAPY	209,647	0	209,647	0	209,647	67.00
68.00	06800	SPEECH PATHOLOGY	89,821	0	89,821	0	89,821	68.00
69.00	06900	ELECTROCARDIOLOGY	1,314,259		1,314,259	0	1,314,259	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,123,627		2,123,627	0	2,123,627	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,240,037		5,240,037	0	5,240,037	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,111,389		4,111,389	0	4,111,389	73.00
74.00	07400	RENAL DIALYSIS	246,291		246,291	0	246,291	74.00
76.00	03020	INFUSION SERVICES	135,784		135,784	0	135,784	76.00
76.01	03610	SLEEP LAB	222,390		222,390	0	222,390	76.01
76.02	03030	PULMONARY REHAB	26,423		26,423	0	26,423	76.02
76.03	03951	WOUND CARE	294,338		294,338	0	294,338	76.03
76.97	07697	CARDIAC REHABILITATION	269,156		269,156	0	269,156	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,880,647		4,880,647	0	4,880,647	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,008,158		2,008,158		2,008,158	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	128,684		128,684	0	128,684	95.00
200.00		Subtotal (see instructions)	55,828,115	0	55,828,115	0	55,828,115	200.00
201.00		Less Observation Beds	2,008,158		2,008,158		2,008,158	201.00
202.00		Total (see instructions)	53,819,957	0	53,819,957	0	53,819,957	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/28/2024 12:49 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	24,424,343		24,424,343			30.00
31.00	03100	INTENSIVE CARE UNIT	4,370,444		4,370,444			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,688,575	45,396,917	57,085,492	0.131129	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,182,209	7,996,647	11,178,856	0.066739	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	3,882,917	9,098,423	12,981,340	0.010711	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,915,441	13,529,160	16,444,601	0.157502	0.000000	54.00
56.00	05600	RADIOISOTOPE	2,162,621	6,492,945	8,655,566	0.045041	0.000000	56.00
57.00	05700	CT SCAN	8,213,151	32,028,770	40,241,921	0.019562	0.000000	57.00
58.00	05800	MRI	514,034	5,446,763	5,960,797	0.064479	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	23,461,160	19,425,262	42,886,422	0.042018	0.000000	59.00
60.00	06000	LABORATORY	17,506,320	56,751,017	74,257,337	0.061785	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	463,247	158,980	622,227	0.584833	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	9,954,228	719,809	10,674,037	0.122109	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,354,400	3,880,679	7,235,079	0.191274	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,487,607	538,174	2,025,781	0.103489	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	262,930	199,932	462,862	0.194056	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	8,805,100	11,124,723	19,929,823	0.065944	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,806,337	3,891,541	9,697,878	0.218979	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,639,233	19,744,947	31,384,180	0.166964	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,206,365	9,672,115	20,878,480	0.196920	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,025,201	47,035	1,072,236	0.229698	0.000000	74.00
76.00	03020	INFUSION SERVICES	152,795	467,713	620,508	0.218827	0.000000	76.00
76.01	03610	SLEEP LAB	0	759,031	759,031	0.292992	0.000000	76.01
76.02	03030	PULMONARY REHAB	0	823,391	823,391	0.032090	0.000000	76.02
76.03	03951	WOUND CARE	1,109	0	1,109	265.408476	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	746,018	746,018	0.360790	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,597,640	39,836,420	48,434,060	0.100769	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,267,410	2,599,524	3,866,934	0.519315	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	166,344,817	291,375,936	457,720,753			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	166,344,817	291,375,936	457,720,753			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/28/2024 12:49 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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03020	INFUSION SERVICES	0.000000	76.00
76.01	03610	SLEEP LAB	0.000000	76.01
76.02	03030	PULMONARY REHAB	0.000000	76.02
76.03	03951	WOUND CARE	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part I Date/Time Prepared: 2/28/2024 12:49 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,260,003	0	1,260,003	6,548	192.43	30.00
31.00	INTENSIVE CARE UNIT	555,106		555,106	693	801.02	31.00
200.00	Total (lines 30 through 199)	1,815,109		1,815,109	7,241		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	2,010	386,784				30.00
31.00	INTENSIVE CARE UNIT	293	234,699				31.00
200.00	Total (lines 30 through 199)	2,303	621,483				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/28/2024 12:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	884,559	57,085,492	0.015495	4,616,070	71,526	50.00
51.00	05100	RECOVERY ROOM	56,954	11,178,856	0.005095	1,241,663	6,326	51.00
53.00	05300	ANESTHESIOLOGY	15,983	12,981,340	0.001231	1,630,969	2,008	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	380,996	16,444,601	0.023168	1,068,473	24,754	54.00
56.00	05600	RADIOISOTOPE	32,957	8,655,566	0.003808	697,788	2,657	56.00
57.00	05700	CT SCAN	66,827	40,241,921	0.001661	2,951,851	4,903	57.00
58.00	05800	MRI	52,555	5,960,797	0.008817	189,736	1,673	58.00
59.00	05900	CARDIAC CATHETERIZATION	127,733	42,886,422	0.002978	6,807,641	20,273	59.00
60.00	06000	LABORATORY	265,216	74,257,337	0.003572	6,965,171	24,880	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	14,003	622,227	0.022505	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	63,214	10,674,037	0.005922	4,207,269	24,915	65.00
66.00	06600	PHYSICAL THERAPY	257,950	7,235,079	0.035653	1,481,512	52,820	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,210	2,025,781	0.005040	619,364	3,122	67.00
68.00	06800	SPEECH PATHOLOGY	5,007	462,862	0.010817	121,954	1,319	68.00
69.00	06900	ELECTROCARDIOLOGY	176,929	19,929,823	0.008878	3,568,891	31,685	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	44,113	9,697,878	0.004549	2,614,026	11,891	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	110,788	31,384,180	0.003530	4,217,616	14,888	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	135,708	20,878,480	0.006500	4,124,433	26,809	73.00
74.00	07400	RENAL DIALYSIS	14,989	1,072,236	0.013979	487,089	6,809	74.00
76.00	03020	INFUSION SERVICES	4,762	620,508	0.007674	39,310	302	76.00
76.01	03610	SLEEP LAB	86,677	759,031	0.114194	0	0	76.01
76.02	03030	PULMONARY REHAB	733	823,391	0.000890	0	0	76.02
76.03	03951	WOUND CARE	103,960	1,109	93.742110	1,109	103,960	76.03
76.97	07697	CARDIAC REHABILITATION	8,536	746,018	0.011442	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	492,378	48,434,060	0.010166	3,237,722	32,915	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	300,762	3,866,934	0.077778	558,765	43,460	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	3,714,499	428,925,966		51,448,422	513,895	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part III Date/Time Prepared: 2/28/2024 12:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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	6,548	0.00	2,010	30.00
31.00	03100	INTENSIVE CARE UNIT		0	693	0.00	293	31.00
200.00		Total (lines 30 through 199)		0	7,241		2,303	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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/28/2024 12:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	INFUSION SERVICES	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03030	PULMONARY REHAB	0	0	0	0	0	76.02
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/28/2024 12:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	57,085,492	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	11,178,856	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	12,981,340	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,444,601	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	8,655,566	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	40,241,921	0.000000	57.00
58.00	05800	MRI	0	0	0	5,960,797	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	42,886,422	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	74,257,337	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	622,227	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,674,037	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,235,079	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,025,781	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	462,862	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	19,929,823	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	9,697,878	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,384,180	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	20,878,480	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,072,236	0.000000	74.00
76.00	03020	INFUSION SERVICES	0	0	0	620,508	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	759,031	0.000000	76.01
76.02	03030	PULMONARY REHAB	0	0	0	823,391	0.000000	76.02
76.03	03951	WOUND CARE	0	0	0	1,109	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	746,018	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	48,434,060	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,866,934	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	428,925,966		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/28/2024 12:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	4,616,070	0	11,361,842	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,241,663	0	1,792,665	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,630,969	0	2,240,287	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,068,473	0	3,150,794	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	697,788	0	1,451,175	0	56.00
57.00	05700	CT SCAN	0.000000	2,951,851	0	7,218,344	0	57.00
58.00	05800	MRI	0.000000	189,736	0	1,261,686	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	6,807,641	0	7,105,617	0	59.00
60.00	06000	LABORATORY	0.000000	6,965,171	0	4,456,714	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,207,269	0	176,247	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,481,512	0	92,374	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	619,364	0	35,294	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	121,954	0	2,136	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,568,891	0	2,895,899	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,614,026	0	1,037,748	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,217,616	0	6,974,587	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,124,433	0	2,726,299	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	487,089	0	47,035	0	74.00
76.00	03020	INFUSION SERVICES	0.000000	39,310	0	69,954	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	157,362	0	76.01
76.02	03030	PULMONARY REHAB	0.000000	0	0	255,166	0	76.02
76.03	03951	WOUND CARE	0.000000	1,109	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	437,830	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	3,237,722	0	7,110,193	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	558,765	0	733,956	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		51,448,422	0	62,791,204	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/28/2024 12:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.131129	11,361,842	0	0	1,489,867	50.00
51.00	05100	RECOVERY ROOM	0.066739	1,792,665	0	0	119,641	51.00
53.00	05300	ANESTHESIOLOGY	0.010711	2,240,287	0	0	23,996	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.157502	3,150,794	0	0	496,256	54.00
56.00	05600	RADIOISOTOPE	0.045041	1,451,175	0	0	65,362	56.00
57.00	05700	CT SCAN	0.019562	7,218,344	0	0	141,205	57.00
58.00	05800	MRI	0.064479	1,261,686	0	0	81,352	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.042018	7,105,617	0	0	298,564	59.00
60.00	06000	LABORATORY	0.061785	4,456,714	0	0	275,358	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.584833	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.122109	176,247	0	0	21,521	65.00
66.00	06600	PHYSICAL THERAPY	0.191274	92,374	0	0	17,669	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.103489	35,294	0	0	3,653	67.00
68.00	06800	SPEECH PATHOLOGY	0.194056	2,136	0	0	415	68.00
69.00	06900	ELECTROCARDIOLOGY	0.065944	2,895,899	0	0	190,967	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.218979	1,037,748	0	0	227,245	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.166964	6,974,587	0	0	1,164,505	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196920	2,726,299	0	0	536,863	73.00
74.00	07400	RENAL DIALYSIS	0.229698	47,035	0	0	10,804	74.00
76.00	03020	INFUSION SERVICES	0.218827	69,954	0	0	15,308	76.00
76.01	03610	SLEEP LAB	0.292992	157,362	0	0	46,106	76.01
76.02	03030	PULMONARY REHAB	0.032090	255,166	0	0	8,188	76.02
76.03	03951	WOUND CARE	265.408476	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.360790	437,830	0	0	157,965	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.100769	7,110,193	0	0	716,487	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.519315	733,956	0	0	381,154	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		62,791,204	0	0	6,490,451	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		62,791,204	0	0	6,490,451	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/28/2024 12:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	INFUSION SERVICES	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.02	03030	PULMONARY REHAB	0	0		76.02
76.03	03951	WOUND CARE	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/28/2024 12:49 pm

Title XIX | 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	0.131129	0	0	418,029	0	50.00
51.00	05100	RECOVERY ROOM	0.066739	0	0	285,662	0	51.00
53.00	05300	ANESTHESIOLOGY	0.010711	0	0	113,384	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.157502	0	0	163,852	0	54.00
56.00	05600	RADIOISOTOPE	0.045041	0	0	35,778	0	56.00
57.00	05700	CT SCAN	0.019562	0	0	650,652	0	57.00
58.00	05800	MRI	0.064479	0	0	56,198	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.042018	0	0	143,248	0	59.00
60.00	06000	LABORATORY	0.061785	0	0	532,891	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.584833	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.122109	0	0	22,628	0	65.00
66.00	06600	PHYSICAL THERAPY	0.191274	0	0	34,325	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.103489	0	0	2,154	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.194056	0	0	1,726	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.065944	0	0	90,121	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.218979	0	0	217,729	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.166964	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196920	0	0	161,393	0	73.00
74.00	07400	RENAL DIALYSIS	0.229698	0	0	0	0	74.00
76.00	03020	INFUSION SERVICES	0.218827	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.292992	0	0	0	0	76.01
76.02	03030	PULMONARY REHAB	0.032090	0	0	0	0	76.02
76.03	03951	WOUND CARE	265.408476	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.360790	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.100769	0	0	935,404	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.519315	0	0	24,370	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	0	3,889,544	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	0	3,889,544	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/28/2024 12:49 pm

Title XIX | 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	0	54,816		50.00
51.00	05100	RECOVERY ROOM	0	19,065		51.00
53.00	05300	ANESTHESIOLOGY	0	1,214		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,807		54.00
56.00	05600	RADIOISOTOPE	0	1,611		56.00
57.00	05700	CT SCAN	0	12,728		57.00
58.00	05800	MRI	0	3,624		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	6,019		59.00
60.00	06000	LABORATORY	0	32,925		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	2,763		65.00
66.00	06600	PHYSICAL THERAPY	0	6,565		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	223		67.00
68.00	06800	SPEECH PATHOLOGY	0	335		68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,943		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	47,678		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	31,782		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	INFUSION SERVICES	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.02	03030	PULMONARY REHAB	0	0		76.02
76.03	03951	WOUND CARE	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	94,260		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	12,656		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	360,014		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	360,014		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/28/2024 12:49 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,548	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,548	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)	4,985	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)	2,010	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,412,937	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,412,937	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	8,412,937	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,284.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,582,468	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,582,468	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/28/2024 12:49 pm

Title XVIII | Hospital | 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	4,151,268	693	5,990.29	293	1,755,155	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	5,931,997	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)	10,269,620	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)	621,483	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	513,895	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,135,378	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	9,134,242	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)	1,563	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,284.81	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,008,158	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/28/2024 12:49 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,260,003	8,412,937	0.149770	2,008,158	300,762	90.00
91.00	Nursing Program cost	0	8,412,937	0.000000	2,008,158	0	91.00
92.00	Allied health cost	0	8,412,937	0.000000	2,008,158	0	92.00
93.00	All other Medical Education	0	8,412,937	0.000000	2,008,158	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/28/2024 12:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		9,421,822		30.00
31.00	03100	INTENSIVE CARE UNIT		1,850,491		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.131129	4,616,070	605,301	50.00
51.00	05100	RECOVERY ROOM	0.066739	1,241,663	82,867	51.00
53.00	05300	ANESTHESIOLOGY	0.010711	1,630,969	17,469	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.157502	1,068,473	168,287	54.00
56.00	05600	RADIOISOTOPE	0.045041	697,788	31,429	56.00
57.00	05700	CT SCAN	0.019562	2,951,851	57,744	57.00
58.00	05800	MRI	0.064479	189,736	12,234	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.042018	6,807,641	286,043	59.00
60.00	06000	LABORATORY	0.061785	6,965,171	430,343	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.584833	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.122109	4,207,269	513,745	65.00
66.00	06600	PHYSICAL THERAPY	0.191274	1,481,512	283,375	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.103489	619,364	64,097	67.00
68.00	06800	SPEECH PATHOLOGY	0.194056	121,954	23,666	68.00
69.00	06900	ELECTROCARDIOLOGY	0.065944	3,568,891	235,347	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.218979	2,614,026	572,417	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.166964	4,217,616	704,190	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196920	4,124,433	812,183	73.00
74.00	07400	RENAL DIALYSIS	0.229698	487,089	111,883	74.00
76.00	03020	INFUSION SERVICES	0.218827	39,310	8,602	76.00
76.01	03610	SLEEP LAB	0.292992	0	0	76.01
76.02	03030	PULMONARY REHAB	0.032090	0	0	76.02
76.03	03951	WOUND CARE	265.408476	1,109	294,338	76.03
76.97	07697	CARDIAC REHABILITATION	0.360790	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.100769	3,237,722	326,262	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.519315	558,765	290,175	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		51,448,422	5,931,997	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)		51,448,422		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/28/2024 12:49 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		73,554		30.00
31.00	03100	INTENSIVE CARE UNIT		56,841		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.131129	51,049	6,694	50.00
51.00	05100	RECOVERY ROOM	0.066739	13,902	928	51.00
53.00	05300	ANESTHESIOLOGY	0.010711	20,540	220	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.157502	5,023	791	54.00
56.00	05600	RADIOISOTOPE	0.045041	13,223	596	56.00
57.00	05700	CT SCAN	0.019562	27,747	543	57.00
58.00	05800	MRI	0.064479	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.042018	0	0	59.00
60.00	06000	LABORATORY	0.061785	78,672	4,861	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.584833	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.122109	60,965	7,444	65.00
66.00	06600	PHYSICAL THERAPY	0.191274	5,851	1,119	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.103489	6,691	692	67.00
68.00	06800	SPEECH PATHOLOGY	0.194056	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.065944	49,129	3,240	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.218979	19,397	4,248	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.166964	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196920	84,023	16,546	73.00
74.00	07400	RENAL DIALYSIS	0.229698	0	0	74.00
76.00	03020	INFUSION SERVICES	0.218827	5,887	1,288	76.00
76.01	03610	SLEEP LAB	0.292992	0	0	76.01
76.02	03030	PULMONARY REHAB	0.032090	0	0	76.02
76.03	03951	WOUND CARE	265.408476	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.360790	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.100769	1,922	194	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.519315	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		444,021	49,404	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)		444,021		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0184	Period: From 01/14/2023 To 09/30/2023	Worksheet E Part A Date/Time Prepared: 2/28/2024 12:49 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	5,662,722	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	0	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	177,853	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	2.04
3.00	Managed Care Simulated Payments	2,402,266	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	87.99	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	7.31	30.00
31.00	Percentage of Medicaid patient days (see instructions)	16.19	31.00
32.00	Sum of lines 30 and 31	23.50	32.00
33.00	Allowable disproportionate share percentage (see instructions)	8.60	33.00
34.00	Disproportionate share adjustment (see instructions)	121,749	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0184	Period: From 01/14/2023 To 09/30/2023	Worksheet E Part A Date/Time Prepared: 2/28/2024 12:49 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,874,403,459	0	35.00
35.01	Factor 3 (see instructions)	0.000043760	0.000000000	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	300,824	0	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	214,286	0	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	214,286		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	6,176,610		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	6,176,610	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	444,706	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	10,998	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	6,632,314	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	6,632,314	61.00
62.00	Deductibles billed to program beneficiaries	577,512	62.00
63.00	Coinsurance billed to program beneficiaries	18,800	63.00
64.00	Allowable bad debts (see instructions)	0	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	0	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	6,036,002	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)	0	70.75
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	0	70.93
70.94	HRR adjustment amount (see instructions)	-2,837	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet E Part A Date/Time Prepared: 2/28/2024 12:49 pm

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,033,165	71.00
71.01	Sequestration adjustment (see instructions)		120,663	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		5,971,841	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-59,339	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		833,576	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/28/2024 12:49 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,662,722	0	5,662,722		5,662,722	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0		0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	177,853	0	177,853		177,853	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	2,402,266	0	2,402,266	0	2,402,266	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0860	0.0860	0.0860	0.0860		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	121,749	0	121,749	0	121,749	11.00
11.01	Uncompensated care payments	36.00	214,286	0	214,286	0	214,286	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,176,610	0	6,176,610	0	6,176,610	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,176,610	0	6,176,610	0	6,176,610	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	444,706	0	444,706	0	444,706	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/28/2024 12:49 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	10,998	0	10,998	0	10,998	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	6,632,314	0	6,632,314	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	421,186	0	421,186	0	421,186	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	23,520	0	23,520	0	23,520	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	444,706	0	444,706	0	444,706	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/28/2024 12:49 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,662,722	5,662,722		5,662,722	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0		0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	177,853	177,853		177,853	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	2,402,266	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0860	0.0860	0.0860		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	121,749	121,749	0	121,749	11.00
11.01	Uncompensated care payments	36.00	214,286	214,286	0	214,286	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,176,610	6,176,610	0	6,176,610	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,176,610	6,176,610	0	6,176,610	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	444,706	444,706	0	444,706	16.00
17.00	Special add-on payments for new technologies	54.00	10,998	10,998	0	10,998	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			6,632,314	0	6,632,314	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/28/2024 12:49 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	421,186	421,186	0	421,186	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	23,520	23,520	0	23,520	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	444,706	444,706	0	444,706	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-2,837	-2,837	0	-2,837	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0184	Period: From 01/14/2023 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/28/2024 12:49 pm
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	6,490,451	2.00
3.00	OPPS or REH payments	4,237,291	3.00
4.00	Outlier payment (see instructions)	74,263	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	4,311,554	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	762,235	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,549,319	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	3,549,319	30.00
31.00	Primary payer payments	683	31.00
32.00	Subtotal (line 30 minus line 31)	3,548,636	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	3,548,636	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)	3,548,636	40.00
40.01	Sequestration adjustment (see instructions)	70,973	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	3,615,270	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)	-137,607	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	469,965	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: 14-0184	Period: From 01/14/2023 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/28/2024 12:49 pm
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		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet E-1 Part I Date/Time Prepared: 2/28/2024 12:49 pm

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,971,841		3,615,270	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)		5,971,841		3,615,270	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		59,339		137,607	6.02
7.00	Total Medicare program liability (see instructions)		5,912,502		3,477,663	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0184	Period: From 01/14/2023 To 09/30/2023	Worksheet E-1 Part II Date/Time Prepared: 2/28/2024 12:49 pm
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			1.00
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (see instructions)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (see instructions)		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 14-0184	Period: From 01/14/2023 To 09/30/2023	Worksheet E-5 Date/Time Prepared: 2/28/2024 12:49 pm
	Title XVIII		PPS

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet G | Date/Time Prepared: 2/28/2024 12:49 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	3,923,978	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	9,542,109	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	3,216,728	0	0	0	7.00
8.00	Prepaid expenses	771,507	0	0	0	8.00
9.00	Other current assets	-1,716,109	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)	15,738,213	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	9,905,276	0	0	0	19.00
20.00	Accumulated depreciation	-1,606,710	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	8,298,566	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	2,463,699	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,463,699	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	26,500,478	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	31,914,126	0	0	0	37.00
38.00	Salaries, wages, and fees payable	-1,033,939	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	0	0	0	0	43.00
44.00	Other current liabilities	-39,661,489	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-8,781,302	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	15,018,656	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	15,018,656	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	6,237,354	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	20,263,124				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	20,263,124	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	26,500,478	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet G-1 | Date/Time Prepared: 2/28/2024 12:49 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		13,959,173		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,069,935				2.00
3.00	Total (sum of line 1 and line 2)		20,029,108		0		3.00
4.00	PAID IN CAPITAL	234,017		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		234,017		0		10.00
11.00	Subtotal (line 3 plus line 10)		20,263,125		0		11.00
12.00	ROUNDING	1		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		1		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		20,263,124		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	PAID IN CAPITAL		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	ROUNDING		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/28/2024 12:49 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	24,424,343		24,424,343	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	24,424,343		24,424,343	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	4,370,444		4,370,444	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	4,370,444		4,370,444	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	28,794,787		28,794,787	17.00
18.00	Ancillary services	127,684,979	248,939,991	376,624,970	18.00
19.00	Outpatient services	9,865,050	42,464,964	52,330,014	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	166,344,816	291,404,955	457,749,771	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		70,496,488		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		70,496,488		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0184 | Period: From 01/14/2023 To 09/30/2023 | Worksheet G-3 | Date/Time Prepared: 2/28/2024 12:49 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	457,749,771	1.00
2.00	Less contractual allowances and discounts on patients' accounts	382,456,170	2.00
3.00	Net patient revenues (line 1 minus line 2)	75,293,601	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	70,496,488	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,797,113	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,155,066	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	117,756	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 (SPECIFY)	0	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	1,272,822	25.00
26.00	Total (line 5 plus line 25)	6,069,935	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,069,935	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0184	Period: From 01/14/2023 To 09/30/2023	Worksheet L Parts I-III Date/Time Prepared: 2/28/2024 12:49 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	421,186	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	23,520	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	21.84	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	444,706	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00