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: 14-1350	Period: From 07/01/2022 To 06/30/2023	Worksheet S Parts I-III Date/Time Prepared: 1/24/2024 11:37 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 1/24/2024 Time: 11:37 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. FRANCIS HOSPITAL (14-1350) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

		Title V	Title XVIII 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	-449,551	242,347	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	7,409	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	-442,142	242,347	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: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 1/24/2024 11:37 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1215 FRANCISCAN DRIVE	PO Box:			1.00
2.00	City: LITCHFIELD	State: IL	Zip Code: 62056	County: MONTGOMERY	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	ST. FRANCIS HOSPITAL	141350	99914	1	12/01/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. FRANCIS HOSPITAL	14Z350	99914		05/31/2007	N	O	O	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)	07/01/2022	06/30/2023	20.00
21.00	Type of Control (see instructions)	1		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 1/24/2024 11:37 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 1/24/2024 11:37 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 1/24/2024 11:37 am

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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

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

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

		Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
		1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.	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.	N	N	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	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.	N	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.	N	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.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	Y	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: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 1/24/2024 11:37 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	84,224	432,000	530,605	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.	Y	5.03	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H005	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: HOSPITAL SISTERS HEALTH SYSTEM	Contractor's Name: NATIONA GOVERNMENT SERVICES	Contractor's Number: 00131	141.00
142.00	Street: 4936 LAVERNA ROAD	PO Box:		142.00
143.00	City: SPRINGFIELD	State: IL	Zip Code: 62707	143.00

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

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

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

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

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		0.00	169.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 1/24/2024 11:37 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/01/2023	Y	11/01/2023	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II Date/Time Prepared: 1/24/2024 11:37 am

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	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.	PATTY	RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	FORVIS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544	PATTY.RACHELL@FORVIS.COM	43.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 1/24/2024 11:37 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	72,843.08	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)		25	9,125	72,843.08	0	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	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	72,843.08	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				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: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 1/24/2024 11:37 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,521	38	2,944			1.00
2.00	HMO and other (see instructions)	710	0				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	251	0	338			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	39			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,772	38	3,321			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		49	272			13.00
14.00	Total (see instructions)	1,772	87	3,593	0.00	192.04	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			15			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	192.04	27.00
28.00	Observation Bed Days		12	617			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			7			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	34	84			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: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 1/24/2024 11:37 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	434	12	999	1.00
2.00	HMO and other (see instructions)			214	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	434	12	999	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 UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-10 | Date/Time Prepared: 1/24/2024 11:37 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.235628	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,942,473	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?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	36,728,110	6.00
7.00	Medicaid cost (line 1 times line 6)	8,654,171	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,711,698	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,711,698	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,213,796	257,306	1,471,102	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	286,004	257,306	543,310	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	286,004	257,306	543,310	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,425,532	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	935,046	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,438,532	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,987,000	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	971,679	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,514,989	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,226,687	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 1/24/2024 11:37 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		442,398	442,398	1,270,267	1,712,665	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,209,030	2,209,030	-1,181,564	1,027,466	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,674,419	4,674,419	0	4,674,419	4.00
5.01	00570	ADMITTING	0	1,688	1,688	0	1,688	5.01
5.02	00540	PATIENT ACCOUNTING	0	0	0	0	0	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	844,208	8,999,163	9,843,371	-128,542	9,714,829	5.03
6.00	00600	MAINTENANCE & REPAIRS	27,053	91,839	118,892	56,381	175,273	6.00
7.00	00700	OPERATION OF PLANT	365,810	1,460,049	1,825,859	58,714	1,884,573	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	133,733	133,733	8.00
9.00	00900	HOUSEKEEPING	361,973	287,344	649,317	0	649,317	9.00
10.00	01000	DIETARY	369,870	319,927	689,797	-349,035	340,762	10.00
11.00	01100	CAFETERIA	0	0	0	349,035	349,035	11.00
13.00	01300	NURSING ADMINISTRATION	846,403	-6,622	839,781	0	839,781	13.00
15.00	01500	PHARMACY	603,200	5,498,766	6,101,966	-5,201,582	900,384	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	78	78	0	78	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,139,130	382,829	3,521,959	-1,366,836	2,155,123	30.00
43.00	04300	NURSERY	0	0	0	136,648	136,648	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,359,467	2,400,189	3,759,656	-521,965	3,237,691	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	954,558	954,558	52.00
53.00	05300	ANESTHESIOLOGY	0	1,477,670	1,477,670	-26,955	1,450,715	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	688,441	160,044	848,485	-42,710	805,775	54.00
54.01	05401	ULTRASOUND	206,602	137,049	343,651	14,552	358,203	54.01
54.02	05402	NUCLEAR MEDICINE	83,722	112,729	196,451	5,383	201,834	54.02
57.00	05700	CT SCAN	76,039	214,671	290,710	-575	290,135	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	88,256	152,718	240,974	2,602	243,576	58.00
60.00	06000	LABORATORY	864,870	1,214,249	2,079,119	209,657	2,288,776	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	350,744	350,744	64.00
65.00	06500	RESPIRATORY THERAPY	432,112	405,834	837,946	-47,208	790,738	65.00
66.00	06600	PHYSICAL THERAPY	496	946,203	946,699	-3,414	943,285	66.00
67.00	06700	OCCUPATIONAL THERAPY	45,317	16,546	61,863	0	61,863	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,744	8,744	0	8,744	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	126,587	126,587	230,039	356,626	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	444,715	444,715	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,208,488	5,208,488	73.00
76.00	03020	WOUND CARE	340,080	629,539	969,619	-23	969,596	76.00
76.97	07697	CARDIAC REHABILITATION	222,694	16,709	239,403	0	239,403	76.97
76.98	07698	SLEEP LAB	90,932	25,008	115,940	-1,898	114,042	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	649,223	1,205,502	1,854,725	-2,522	1,852,203	90.00
90.01	09001	ONCOLOGY CLINIC	470,179	748,466	1,218,645	-325,709	892,936	90.01
91.00	09100	EMERGENCY	1,835,881	1,810,504	3,646,385	-107,094	3,539,291	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,011,958	36,169,869	50,181,827	117,884	50,299,711	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	46,423	46,423	0	46,423	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	227,433	171,146	398,579	-117,884	280,695	192.00
194.00	07950	OTHER NONALLOWABLE	76,985	215,994	292,979	0	292,979	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	14,316,376	36,603,432	50,919,808	0	50,919,808	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 1/24/2024 11:37 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-78,106	1,634,559		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-73,723	953,743		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,723,309	2,951,110		4.00
5.01	00570	ADMITTING	189,913	191,601		5.01
5.02	00540	PATIENT ACCOUNTING	725,656	725,656		5.02
5.03	00550	ADMINISTRATIVE & GENERAL	-3,657,224	6,057,605		5.03
6.00	00600	MAINTENANCE & REPAIRS	0	175,273		6.00
7.00	00700	OPERATION OF PLANT	-6,063	1,878,510		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-24,606	109,127		8.00
9.00	00900	HOUSEKEEPING	0	649,317		9.00
10.00	01000	DIETARY	0	340,762		10.00
11.00	01100	CAFETERIA	0	349,035		11.00
13.00	01300	NURSING ADMINISTRATION	-1,225	838,556		13.00
15.00	01500	PHARMACY	0	900,384		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	514,980	515,058		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-31,000	2,124,123		30.00
43.00	04300	NURSERY	0	136,648		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-272,571	2,965,120		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	954,558		52.00
53.00	05300	ANESTHESIOLOGY	-1,429,189	21,526		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	805,775		54.00
54.01	05401	ULTRASOUND	0	358,203		54.01
54.02	05402	NUCLEAR MEDICINE	0	201,834		54.02
57.00	05700	CT SCAN	0	290,135		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	243,576		58.00
60.00	06000	LABORATORY	-45,438	2,243,338		60.00
64.00	06400	INTRAVENOUS THERAPY	0	350,744		64.00
65.00	06500	RESPIRATORY THERAPY	-261,975	528,763		65.00
66.00	06600	PHYSICAL THERAPY	0	943,285		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	61,863		67.00
68.00	06800	SPEECH PATHOLOGY	0	8,744		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	356,626		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	444,715		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,208,488		73.00
76.00	03020	WOUND CARE	-121,868	847,728		76.00
76.97	07697	CARDIAC REHABILITATION	0	239,403		76.97
76.98	07698	SLEEP LAB	0	114,042		76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-1,192,664	659,539		90.00
90.01	09001	ONCOLOGY CLINIC	-640,819	252,117		90.01
91.00	09100	EMERGENCY	-761,828	2,777,463		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,891,059	41,408,652		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	46,423		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	280,695		192.00
194.00	07950	OTHER NONALLOWABLE	0	292,979		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,891,059	42,028,749		200.00

RECLASSIFICATIONS | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 1/24/2024 11:37 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - L&D AND NURSERY SAL & OTHER EXP				
1.00	NURSERY	43.00	121,672	14,980	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	851,940	104,889	2.00
	0		973,612	119,869	
	B - DRUG COSTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,208,488	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	97	2.00
3.00		0.00	0	0	3.00
5.00		0.00	0	0	5.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	0		0	5,208,585	
	C - CAFETERIA SALARIES & OTHER COSTS				
1.00	CAFETERIA	11.00	187,153	161,882	1.00
	0		187,153	161,882	
	D - LAUNDRY COSTS				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	133,733	1.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
	0		0	133,733	
	E - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	300,290	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	374,464	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
	0		0	674,754	
	F - LAB ADMINISTRATION COSTS				
1.00	LABORATORY	60.00	147,273	23,432	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
	0		147,273	23,432	
	I - BUILDING INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	75,554	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	13,143	2.00
	0		0	88,697	
	J - RADIOLOGY MANAGERS COST				
1.00	ULTRASOUND	54.01	15,370	0	1.00
2.00	NUCLEAR MEDICINE	54.02	6,309	0	2.00
3.00	CT SCAN	57.00	6,712	0	3.00
4.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	6,712	0	4.00
	0		35,103	0	
	N - INTEREST				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6	1.00
	0		0	6	
	O - IMPLANT COSTS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	70,251	1.00
	0		0	70,251	

RECLASSIFICATIONS | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 1/24/2024 11:37 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	P - DEPRECIATION EXPENSE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,194,707		1.00
	0		0	1,194,707		
	Q - MOB OVERHEAD					
1.00	MAINTENANCE & REPAIRS	6.00	0	56,521		1.00
2.00	OPERATION OF PLANT	7.00	0	58,720		2.00
	0		0	115,241		
	R - COVID EXPENSES					
1.00	LABORATORY	60.00	0	39,845		1.00
	0		0	39,845		
	S - IV THERAPY					
1.00	INTRAVENOUS THERAPY	64.00	325,043	0		1.00
2.00	INTRAVENOUS THERAPY	64.00	39,965	0		2.00
	0		365,008	0		
500.00	Grand Total: Increases		1,708,149	7,831,002		500.00

RECLASSIFICATIONS | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 1/24/2024 11:37 am

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - L&D AND NURSERY SAL & OTHER EXP					
1.00	ADULTS & PEDIATRICS	30.00	973,612	119,869	0	1.00
2.00		0.00	0	0	0	2.00
	0		973,612	119,869		
	B - DRUG COSTS					
1.00		0.00	0	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00	PHARMACY	15.00	0	5,201,582	0	3.00
5.00	OPERATING ROOM	50.00	0	326	0	5.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	35	0	7.00
8.00	ULTRASOUND	54.01	0	111	0	8.00
10.00	CT SCAN	57.00	0	4,513	0	10.00
11.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	543	0	11.00
14.00	EMERGENCY	91.00	0	1,452	0	14.00
15.00	WOUND CARE	76.00	0	23	0	15.00
	0		0	5,208,585		
	C - CAFETERIA SALARIES & OTHER COSTS					
1.00	DIETARY	10.00	187,153	161,882	0	1.00
	0		187,153	161,882		
	D - LAUNDRY COSTS					
1.00	MAINTENANCE & REPAIRS	6.00	0	140	0	1.00
4.00	ADULTS & PEDIATRICS	30.00	0	67,112	0	4.00
5.00	NURSERY	43.00	0	4	0	5.00
6.00	OPERATING ROOM	50.00	0	18,797	0	6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	30	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	7,572	0	8.00
9.00	ULTRASOUND	54.01	0	707	0	9.00
10.00	NUCLEAR MEDICINE	54.02	0	926	0	10.00
11.00	CT SCAN	57.00	0	2,774	0	11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	3,567	0	12.00
13.00	LABORATORY	60.00	0	893	0	13.00
14.00	RESPIRATORY THERAPY	65.00	0	2,122	0	14.00
15.00	PHYSICAL THERAPY	66.00	0	3,414	0	15.00
16.00	SLEEP LAB	76.98	0	1,898	0	16.00
17.00	CLINIC	90.00	0	2,522	0	17.00
18.00	ONCOLOGY CLINIC	90.01	0	666	0	18.00
19.00	EMERGENCY	91.00	0	17,946	0	19.00
20.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,643	0	20.00
	0		0	133,733		
	E - MEDICAL SUPPLIES					
1.00	ADULTS & PEDIATRICS	30.00	0	42,815	0	1.00
2.00	OPERATING ROOM	50.00	0	502,842	0	2.00
3.00	ANESTHESIOLOGY	53.00	0	26,955	0	3.00
4.00	EMERGENCY	91.00	0	57,056	0	4.00
5.00	RESPIRATORY THERAPY	65.00	0	45,086	0	5.00
	0		0	674,754		
	F - LAB ADMINISTRATION COSTS					
1.00	ADULTS & PEDIATRICS	30.00	115,257	8,303	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,995	246	0	2.00
3.00	INTRAVENOUS THERAPY	64.00	14,264	0	0	3.00
4.00	EMERGENCY	91.00	15,757	14,883	0	4.00
	0		147,273	23,432		
	I - BUILDING INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.03	0	88,697	12	1.00
2.00		0.00	0	0	12	2.00
	0		0	88,697		
	J - RADIOLOGY MANAGERS COST					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	35,103	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
	0		35,103	0		
	N - INTEREST					
1.00	OPERATION OF PLANT	7.00	0	6	11	1.00
	0		0	6		
	O - IMPLANT COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	70,251	0	1.00
	0		0	70,251		

RECLASSIFICATIONS | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 1/24/2024 11:37 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	P - DEPRECIATION EXPENSE RECLASS						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,194,707	9		1.00
	0		0	1,194,707			
	Q - MOB OVERHEAD						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	115,241	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	115,241			
	R - COVID EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.03	0	39,845	0		1.00
	0		0	39,845			
	S - IV THERAPY						
1.00	ONCOLOGY CLINIC	90.01	325,043	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	39,965	0	0		2.00
	0		365,008	0			
500.00	Grand Total: Decreases		1,708,149	7,831,002			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 1/24/2024 11:37 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	462,220	0	0	0	0	1.00
2.00	Land Improvements	1,061,051	183,524	0	183,524	0	2.00
3.00	Buildings and Fixtures	10,852,983	0	0	0	0	3.00
4.00	Building Improvements	10,673	49,997	0	49,997	0	4.00
5.00	Fixed Equipment	28,204,821	205,050	0	205,050	0	5.00
6.00	Movable Equipment	14,280,445	1,145,538	0	1,145,538	503,398	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	54,872,193	1,584,109	0	1,584,109	503,398	8.00
9.00	Reconciling Items	487,848	-90,607	0	-90,607	0	9.00
10.00	Total (line 8 minus line 9)	54,384,345	1,674,716	0	1,674,716	503,398	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	462,220	0	1.00
2.00	Land Improvements	1,244,575	0	2.00
3.00	Buildings and Fixtures	10,852,983	0	3.00
4.00	Building Improvements	60,670	0	4.00
5.00	Fixed Equipment	28,409,871	0	5.00
6.00	Movable Equipment	14,922,585	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	55,952,904	0	8.00
9.00	Reconciling Items	397,241	0	9.00
10.00	Total (line 8 minus line 9)	55,555,663	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part II Date/Time Prepared: 1/24/2024 11:37 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	442,398	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,209,030	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,651,428	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	442,398		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,209,030		2.00
3.00	Total (sum of lines 1-2)	0	2,651,428		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 1/24/2024 11:37 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	41,030,319	0	41,030,319	0.733301	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,922,585	0	14,922,585	0.266699	0	2.00
3.00	Total (sum of lines 1-2)	55,952,904	0	55,952,904	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	2,028,188	-26,785	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	940,600	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,968,788	-26,785	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	-442,398	75,554	0	0	1,634,559	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	13,143	0	0	953,743	2.00
3.00	Total (sum of lines 1-2)	-442,398	88,697	0	0	2,588,302	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 1/24/2024 11:37 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-442,404	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-6,063	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,457,229			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	-384,682			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	-56,986	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 1/24/2024 11:37 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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	COMMUNITY BENEFIT	A	-600	ADMINISTRATIVE & GENERAL	5.03	0	33.00
33.01	MISC INCOME	B	-1,843	ADMINISTRATIVE & GENERAL	5.03	0	33.01
33.02	RENTAL INCOME	B	-26,785	CAP REL COSTS-BLDG & FIXT	1.00	10	33.02
33.03	BANK CHARGES	B	35,658	ADMINISTRATIVE & GENERAL	5.03	0	33.03
33.04	HIS MISC INCOME	B	-3,837	MEDICAL RECORDS & LIBRARY	16.00	0	33.04
33.05	LAB MISC INCOME	B	466	LABORATORY	60.00	0	33.05
33.06	ADVERTISING COST	A	-12,800	ADMINISTRATIVE & GENERAL	5.03	0	33.06
33.07	DEFINED PENSION ADJUSTMENT	A	-418,141	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	FUND DEVELOPMENT - SALARY	A	1,922	ADMINISTRATIVE & GENERAL	5.03	0	33.08
33.09	FUND DEVELOPMENT - OTHER	A	-4,827	ADMINISTRATIVE & GENERAL	5.03	0	33.09
33.10	FUND DEVELOPMENT - BENEFITS	A	391	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	SELF-INS TO HOSP/EMP CLIMS	A	-1,105,940	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	PHYSICIAN RECRUITMENT	A	-249,510	ADMINISTRATIVE & GENERAL	5.03	0	33.12
33.13	MEDICAID TAX ASSESSMENT	A	-1,743,389	ADMINISTRATIVE & GENERAL	5.03	0	33.13
33.15	LOBBYING EXPENSES	A	-26,314	ADMINISTRATIVE & GENERAL	5.03	0	33.15
33.16	CHARITABLE CONTRIBUTIONS	A	-16,528	ADMINISTRATIVE & GENERAL	5.03	0	33.16
33.17	NON-PATIENT TRAVEL	A	-2,094	CLINIC	90.00	0	33.17
33.18	ASSET RELIFING-BUILDING	A	391,083	CAP REL COSTS-BLDG & FIXT	1.00	9	33.18
33.19	ASSET RELIFING-EQUIPMENT	A	-73,723	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.19
33.20	GIFTS	A	-18,654	ADMINISTRATIVE & GENERAL	5.03	0	33.20
33.21	GIFTS	A	-810	NURSING ADMINISTRATION	13.00	0	33.21
33.22	GIFTS	A	-344	ONCOLOGY CLINIC	90.01	0	33.22
33.23	MED GROUP PURCHSED SERVICES	A	9,400	ADMINISTRATIVE & GENERAL	5.03	0	33.23
33.24	TAX PENALTIES	A	14,229	ADMINISTRATIVE & GENERAL	5.03	0	33.24
33.25	APRN PT B BENEFITS	A	-49,125	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.25
33.26	APRN PT B SALARIES	A	-122,918	WOUND CARE	76.00	0	33.26
33.27	APRN PT B SALARIES	A	-118,247	CLINIC	90.00	0	33.27
33.28	ADVERTISING COST	A	-415	NURSING ADMINISTRATION	13.00	0	33.28
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,891,059				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: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 1/24/2024 11:37 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH & DENTAL PREMIUM	3,398,815	3,399,350	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HR FEE	84,341	234,300	2.00
3.00	5.03	ADMINISTRATIVE & GENERAL	CONTRACTED SERVICES - ISC	2,256,003	1,551,972	3.00
3.01	5.01	ADMITTING	SBO FEES - ADMITTING	189,913	0	3.01
3.02	5.02	PATIENT ACCOUNTING	SBO FEES - PATIENT ACCOUNTIN	725,656	0	3.02
3.03	5.03	ADMINISTRATIVE & GENERAL	SBO FEES - A&G	0	2,422,476	3.03
3.04	16.00	MEDICAL RECORDS & LIBRARY	SBO FEES - MEDICAL RECORDS	518,817	0	3.04
3.05	5.03	ADMINISTRATIVE & GENERAL	CONTRACTED SERVICES - SSC	1,355,288	1,114,224	3.05
3.06	5.03	ADMINISTRATIVE & GENERAL	PURCHASED SERVICES	0	82,552	3.06
3.07	5.03	ADMINISTRATIVE & GENERAL	HSHS IL HOME OFFICE - OTHER	475,815	561,675	3.07
3.08	5.03	ADMINISTRATIVE & GENERAL	HSHS IL HOME OFFICE - LIBRAR	12,920	11,095	3.08
4.00	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	107,740	132,346	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,125,308	9,509,990	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-1350	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-1 Date/Time Prepared: 1/24/2024 11:37 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-535	0		1.00
2.00	-149,959	0		2.00
3.00	704,031	0		3.00
3.01	189,913	0		3.01
3.02	725,656	0		3.02
3.03	-2,422,476	0		3.03
3.04	518,817	0		3.04
3.05	241,064	0		3.05
3.06	-82,552	0		3.06
3.07	-85,860	0		3.07
3.08	1,825	0		3.08
4.00	-24,606	0		4.00
5.00	-384,682			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	CORPORATE		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: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 1/24/2024 11:37 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.03	ADMINISTRATIVE & GENERAL	41,609	0	41,609	0	0	1.00
2.00	90.00	CLINIC	1,072,323	1,072,323	0	0	0	2.00
3.00	90.01	ONCOLOGY CLINIC	640,475	640,475	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	31,000	31,000	0	0	0	4.00
5.00	91.00	EMERGENCY	48,000	0	48,000	0	0	5.00
6.00	91.00	EMERGENCY	1,598,370	761,828	836,542	0	0	6.00
7.00	76.00	WOUND CARE	-1,050	-1,050	0	0	0	7.00
8.00	53.00	ANESTHESIOLOGY	1,429,189	1,429,189	0	0	0	8.00
9.00	50.00	OPERATING ROOM	272,571	272,571	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	204,989	204,989	0	0	0	10.00
11.00	5.03	ADMINISTRATIVE & GENERAL	388	0	388	0	0	11.00
12.00	5.03	ADMINISTRATIVE & GENERAL	4,500	0	4,500	0	0	12.00
13.00	90.01	ONCOLOGY CLINIC	72,570	0	72,570	0	0	13.00
14.00	60.00	LABORATORY	55,000	45,904	9,096	0	0	14.00
200.00			5,469,934	4,457,229	1,012,705		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	5.03	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	90.00	CLINIC	0	0	0	0	0	2.00
3.00	90.01	ONCOLOGY CLINIC	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	76.00	WOUND CARE	0	0	0	0	0	7.00
8.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	8.00
9.00	50.00	OPERATING ROOM	0	0	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	10.00
11.00	5.03	ADMINISTRATIVE & GENERAL	0	0	0	0	0	11.00
12.00	5.03	ADMINISTRATIVE & GENERAL	0	0	0	0	0	12.00
13.00	90.01	ONCOLOGY CLINIC	0	0	0	0	0	13.00
14.00	60.00	LABORATORY	0	0	0	0	0	14.00
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	5.03	ADMINISTRATIVE & GENERAL	0	0	0	0		1.00
2.00	90.00	CLINIC	0	0	0	1,072,323		2.00
3.00	90.01	ONCOLOGY CLINIC	0	0	0	640,475		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	31,000		4.00
5.00	91.00	EMERGENCY	0	0	0	0		5.00
6.00	91.00	EMERGENCY	0	0	0	761,828		6.00
7.00	76.00	WOUND CARE	0	0	0	-1,050		7.00
8.00	53.00	ANESTHESIOLOGY	0	0	0	1,429,189		8.00
9.00	50.00	OPERATING ROOM	0	0	0	272,571		9.00
10.00	65.00	RESPIRATORY THERAPY	0	0	0	204,989		10.00
11.00	5.03	ADMINISTRATIVE & GENERAL	0	0	0	0		11.00
12.00	5.03	ADMINISTRATIVE & GENERAL	0	0	0	0		12.00
13.00	90.01	ONCOLOGY CLINIC	0	0	0	0		13.00
14.00	60.00	LABORATORY	0	0	0	45,904		14.00
200.00			0	0	0	4,457,229		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1350	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 1/24/2024 11:37 am

Physical Therapy

		Cost	
		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	5.78	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	6,195.50	0.00	4,639.25	0.00	0.00	9.00
10.00	AHSEA (see instructions)	128.46	0.00	71.36	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	0.00	0.00	35.68			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	795,874	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	0	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	331,057	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	1,126,931	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	1,126,931	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	1,126,931	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1350	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 1/24/2024 11:37 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	0.00	71.36	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	1,126,931		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	1,126,931		63.00
64.00	Total cost of outside supplier services (from your records)	904,150		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1350	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 1/24/2024 11:37 am

		Respiratory Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		22	1.00
2.00	Line 1 multiplied by 15 hours per week		330	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.78	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	656.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	74.73	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.37	37.37	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		49,023	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)		0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		49,023	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		49,023	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		0	22.00
23.00	Total salary equivalency (see instructions)		49,023	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
	Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		0	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		0	28.00
	Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 1/24/2024 11:37 am

		Respiratory Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	148.00	0.00	0.00	0.00	148.00	47.00
48.00	Overtime rate (see instructions)	112.10	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	16,590.80	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	100.00	0.00	0.00	0.00	100.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	2,080.00	0.00	0.00	0.00	2,080.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	74.73	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	155,438	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	16,591	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	11,060	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	5,531	0	0	0	5,531	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		49,023	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		5,531	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		54,554	63.00
64.00	Total cost of outside supplier services (from your records)		111,540	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		56,986	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		0	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		0	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1350	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 1/24/2024 11:37 am

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		17	1.00
2.00	Line 1 multiplied by 15 hours per week		255	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.78	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	227.00	107.50	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	90.20	67.65	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	45.10	45.10	33.83			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	20,475	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	7,272	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	27,747	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	27,747	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	27,747	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 1/24/2024 11:37 am

		Occupational Therapy	Cost
		1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	90.20	67.65	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	27,747	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	27,747	63.00
64.00	Total cost of outside supplier services (from your records)	18,203	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1350	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 1/24/2024 11:37 am

		Speech Pathology	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.78	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	116.03	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	86.67	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	43.34	43.34	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		10,056	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)		0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		10,056	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		10,056	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		86.67	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		67,603	22.00
23.00	Total salary equivalency (see instructions)		67,603	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
	Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		0	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		0	28.00
	Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 1/24/2024 11:37 am

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	86.67	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	67,603	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	67,603	63.00
64.00	Total cost of outside supplier services (from your records)	8,122	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 1/24/2024 11:37 am

		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	ADMITTING	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,634,559	1,634,559				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	953,743		953,743			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,951,110	811	698	2,952,619		4.00
5.01	00570	ADMITTING	191,601	34,223	870	0	226,694	5.01
5.02	00540	PATIENT ACCOUNTING	725,656	2,036	0	0	0	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	6,057,605	199,060	141,217	177,472	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	175,273	0	0	5,674	0	6.00
7.00	00700	OPERATION OF PLANT	1,878,510	330,688	35,690	76,727	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	109,127	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	649,317	29,076	0	75,922	0	9.00
10.00	01000	DIETARY	340,762	79,585	1,327	38,324	0	10.00
11.00	01100	CAFETERIA	349,035	26,017	1,359	39,255	0	11.00
13.00	01300	NURSING ADMINISTRATION	838,556	6,205	41,051	177,530	0	13.00
15.00	01500	PHARMACY	900,384	16,578	3,201	126,519	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	515,058	0	49	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,124,123	166,195	22,374	421,647	6,731	30.00
43.00	04300	NURSERY	136,648	7,756	4,413	25,520	410	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,965,120	131,770	272,606	285,143	16,712	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	954,558	39,669	30,912	178,273	2,861	52.00
53.00	05300	ANESTHESIOLOGY	21,526	2,732	29,980	0	9,735	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	805,775	46,112	135,581	137,035	9,358	54.00
54.01	05401	ULTRASOUND	358,203	3,252	68,107	46,558	9,142	54.01
54.02	05402	NUCLEAR MEDICINE	201,834	5,808	37,760	18,884	3,301	54.02
57.00	05700	CT SCAN	290,135	4,698	0	17,357	32,673	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	243,576	15,009	418	19,919	10,730	58.00
60.00	06000	LABORATORY	2,243,338	41,996	9,364	212,293	29,933	60.00
64.00	06400	INTRAVENOUS THERAPY	350,744	27,048	0	73,567	5,098	64.00
65.00	06500	RESPIRATORY THERAPY	528,763	36,373	14,541	90,634	5,620	65.00
66.00	06600	PHYSICAL THERAPY	943,285	43,054	9,034	104	8,701	66.00
67.00	06700	OCCUPATIONAL THERAPY	61,863	2,336	0	9,505	471	67.00
68.00	06800	SPEECH PATHOLOGY	8,744	159	0	0	33	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	356,626	22,280	0	0	3,448	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	444,715	0	0	0	5,201	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,208,488	0	0	0	34,523	73.00
76.00	03020	WOUND CARE	847,728	15,230	3,408	45,549	1,749	76.00
76.97	07697	CARDIAC REHABILITATION	239,403	12,383	0	46,709	889	76.97
76.98	07698	SLEEP LAB	114,042	1,763	6,098	19,073	1,544	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	659,539	14,921	6,370	111,370	7,504	90.00
90.01	09001	ONCOLOGY CLINIC	252,117	10,647	11,093	30,442	819	90.01
91.00	09100	EMERGENCY	2,777,463	113,182	40,201	381,764	19,508	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,408,652	1,488,652	927,722	2,888,769	226,694	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	46,423	8,267	20	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	280,695	136,406	12,777	47,703	0	192.00
194.00	07950	OTHER NONALLOWABLE	292,979	1,234	13,224	16,147	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	42,028,749	1,634,559	953,743	2,952,619	226,694	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 1/24/2024 11:37 am

		Cost Center Description	PATIENT ACCOUNTING	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			5.02	5A.02	5.03	6.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING	727,692					5.02
5.03	00550	ADMINISTRATIVE & GENERAL	0	6,575,354	6,575,354			5.03
6.00	00600	MAINTENANCE & REPAIRS	0	180,947	33,559	214,506		6.00
7.00	00700	OPERATION OF PLANT	0	2,321,615	430,578	50,725	2,802,918	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	109,127	20,239	0	0	8.00
9.00	00900	HOUSEKEEPING	0	754,315	139,899	4,460	76,326	9.00
10.00	01000	DIETARY	0	459,998	85,314	12,208	208,919	10.00
11.00	01100	CAFETERIA	0	415,666	77,091	3,991	68,298	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,063,342	197,213	952	16,288	13.00
15.00	01500	PHARMACY	0	1,046,682	194,123	2,543	43,519	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	515,107	95,534	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,600	2,762,670	512,379	25,493	436,278	30.00
43.00	04300	NURSERY	1,317	176,064	32,654	1,190	20,360	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	53,628	3,724,979	690,853	20,212	345,908	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,179	1,215,452	225,424	6,085	104,136	52.00
53.00	05300	ANESTHESIOLOGY	31,240	95,213	17,659	419	7,172	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,031	1,163,892	215,861	7,073	121,048	54.00
54.01	05401	ULTRASOUND	29,337	514,599	95,440	499	8,537	54.01
54.02	05402	NUCLEAR MEDICINE	10,592	278,179	51,592	891	15,247	54.02
57.00	05700	CT SCAN	104,846	449,709	83,405	721	12,332	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	34,432	324,084	60,106	2,302	39,401	58.00
60.00	06000	LABORATORY	96,052	2,632,976	488,325	6,442	110,244	60.00
64.00	06400	INTRAVENOUS THERAPY	16,359	472,816	87,691	4,149	71,005	64.00
65.00	06500	RESPIRATORY THERAPY	18,034	693,965	128,706	5,579	95,483	65.00
66.00	06600	PHYSICAL THERAPY	27,922	1,032,100	191,418	6,604	113,020	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,512	75,687	14,037	358	6,131	67.00
68.00	06800	SPEECH PATHOLOGY	104	9,040	1,677	24	416	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,065	393,419	72,965	3,418	58,488	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,689	466,605	86,539	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	111,024	5,354,035	992,978	0	0	73.00
76.00	03020	WOUND CARE	5,613	919,277	170,494	2,336	39,979	76.00
76.97	07697	CARDIAC REHABILITATION	2,853	302,237	56,054	1,899	32,506	76.97
76.98	07698	SLEEP LAB	4,954	147,474	27,351	270	4,627	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	24,081	823,785	152,783	2,289	39,169	90.00
90.01	09001	ONCOLOGY CLINIC	2,628	307,746	57,076	1,633	27,948	90.01
91.00	09100	EMERGENCY	62,600	3,394,718	629,601	17,361	297,114	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	727,692	41,172,874	6,416,618	192,126	2,419,899	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	54,710	10,147	1,268	21,702	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	477,581	88,575	20,923	358,078	192.00
194.00	07950	OTHER NONALLOWABLE	0	323,584	60,014	189	3,239	194.00
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	727,692	42,028,749	6,575,354	214,506	2,802,918	202.00

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		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	129,366					8.00
9.00	00900	HOUSEKEEPING	0	975,000				9.00
10.00	01000	DIETARY	0	0	766,439			10.00
11.00	01100	CAFETERIA	0	0	0	565,046		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	31,315	1,309,110	13.00
15.00	01500	PHARMACY	0	0	0	21,445	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	55,518	157,257	766,439	102,980	457,487	30.00
43.00	04300	NURSERY	1,312	20,288	0	4,826	21,440	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,347	176,049	0	60,162	267,271	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,192	142,157	0	33,819	150,239	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,790	12,996	0	37,229	0	54.00
54.01	05401	ULTRASOUND	1,314	5,843	0	8,890	0	54.01
54.02	05402	NUCLEAR MEDICINE	1,326	6,077	0	3,629	0	54.02
57.00	05700	CT SCAN	2,801	3,553	0	3,883	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,279	7,152	0	3,883	0	58.00
60.00	06000	LABORATORY	1,653	13,416	0	47,172	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	19,340	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,153	0	0	21,010	0	65.00
66.00	06600	PHYSICAL THERAPY	3,733	52,403	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	202	2,852	0	1,379	0	67.00
68.00	06800	SPEECH PATHOLOGY	14	187	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	WOUND CARE	1,421	17,203	0	14,006	62,223	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	8,309	36,915	76.97
76.98	07698	SLEEP LAB	1,873	9,490	0	4,717	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,918	40,950	0	36,576	0	90.00
90.01	09001	ONCOLOGY CLINIC	0	0	0	7,693	0	90.01
91.00	09100	EMERGENCY	15,618	171,234	0	70,576	313,535	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	126,464	839,107	766,439	542,839	1,309,110	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	2,902	135,893	0	18,578	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	3,629	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	129,366	975,000	766,439	565,046	1,309,110	202.00

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		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY	1,308,312					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	610,641				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	18,125	0	5,294,626	0	30.00
43.00	04300	NURSERY	0	1,105	0	279,239	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	45,000	0	5,349,781	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,703	0	1,894,207	0	52.00
53.00	05300	ANESTHESIOLOGY	0	26,213	0	146,676	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,199	0	1,586,088	0	54.00
54.01	05401	ULTRASOUND	0	24,617	0	659,739	0	54.01
54.02	05402	NUCLEAR MEDICINE	0	8,888	0	365,829	0	54.02
57.00	05700	CT SCAN	0	87,978	0	644,382	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	28,892	0	469,099	0	58.00
60.00	06000	LABORATORY	0	80,599	0	3,380,827	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	13,727	0	668,728	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	15,133	0	962,029	0	65.00
66.00	06600	PHYSICAL THERAPY	0	23,430	0	1,422,708	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,269	0	101,915	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	88	0	11,446	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,285	0	537,575	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,004	0	567,148	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,308,312	93,184	0	7,748,509	0	73.00
76.00	03020	WOUND CARE	0	4,710	0	1,231,649	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	2,394	0	440,314	0	76.97
76.98	07698	SLEEP LAB	0	4,157	0	199,959	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	20,206	0	1,118,676	0	90.00
90.01	09001	ONCOLOGY CLINIC	0	2,206	0	404,302	0	90.01
91.00	09100	EMERGENCY	0	52,529	0	4,962,286	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,308,312	610,641	0	40,447,737	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	87,827	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,102,530	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	390,655	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,308,312	610,641	0	42,028,749	0	202.00

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		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00540	PATIENT ACCOUNTING			5.02
5.03	00550	ADMINISTRATIVE & GENERAL			5.03
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	5,294,626		30.00
43.00	04300	NURSERY	279,239		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	5,349,781		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,894,207		52.00
53.00	05300	ANESTHESIOLOGY	146,676		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,586,088		54.00
54.01	05401	ULTRASOUND	659,739		54.01
54.02	05402	NUCLEAR MEDICINE	365,829		54.02
57.00	05700	CT SCAN	644,382		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	469,099		58.00
60.00	06000	LABORATORY	3,380,827		60.00
64.00	06400	INTRAVENOUS THERAPY	668,728		64.00
65.00	06500	RESPIRATORY THERAPY	962,029		65.00
66.00	06600	PHYSICAL THERAPY	1,422,708		66.00
67.00	06700	OCCUPATIONAL THERAPY	101,915		67.00
68.00	06800	SPEECH PATHOLOGY	11,446		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	537,575		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	567,148		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,748,509		73.00
76.00	03020	WOUND CARE	1,231,649		76.00
76.97	07697	CARDIAC REHABILITATION	440,314		76.97
76.98	07698	SLEEP LAB	199,959		76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		77.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	1,118,676		90.00
90.01	09001	ONCOLOGY CLINIC	404,302		90.01
91.00	09100	EMERGENCY	4,962,286		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,447,737		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	87,827		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,102,530		192.00
194.00	07950	OTHER NONALLOWABLE	390,655		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	42,028,749		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 1/24/2024 11:37 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	811	698	1,509	1,509	4.00
5.01	00570	ADMITTING	2,030	34,223	870	37,123	0	5.01
5.02	00540	PATIENT ACCOUNTING	7,757	2,036	0	9,793	0	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	1,055,950	199,060	141,217	1,396,227	91	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	3	6.00
7.00	00700	OPERATION OF PLANT	9,230	330,688	35,690	375,608	39	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,410	0	0	6,410	0	8.00
9.00	00900	HOUSEKEEPING	4,060	29,076	0	33,136	39	9.00
10.00	01000	DIETARY	937	79,585	1,327	81,849	20	10.00
11.00	01100	CAFETERIA	0	26,017	1,359	27,376	20	11.00
13.00	01300	NURSING ADMINISTRATION	207	6,205	41,051	47,463	91	13.00
15.00	01500	PHARMACY	92,313	16,578	3,201	112,092	65	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,546	0	49	5,595	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,408	166,195	22,374	195,977	215	30.00
43.00	04300	NURSERY	0	7,756	4,413	12,169	13	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,833	131,770	272,606	410,209	145	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	39,669	30,912	70,581	91	52.00
53.00	05300	ANESTHESIOLOGY	516	2,732	29,980	33,228	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,500	46,112	135,581	183,193	70	54.00
54.01	05401	ULTRASOUND	0	3,252	68,107	71,359	24	54.01
54.02	05402	NUCLEAR MEDICINE	0	5,808	37,760	43,568	10	54.02
57.00	05700	CT SCAN	0	4,698	0	4,698	9	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	15,009	418	15,427	10	58.00
60.00	06000	LABORATORY	19,330	41,996	9,364	70,690	108	60.00
64.00	06400	INTRAVENOUS THERAPY	0	27,048	0	27,048	38	64.00
65.00	06500	RESPIRATORY THERAPY	41,685	36,373	14,541	92,599	46	65.00
66.00	06600	PHYSICAL THERAPY	829	43,054	9,034	52,917	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,336	0	2,336	5	67.00
68.00	06800	SPEECH PATHOLOGY	0	159	0	159	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,654	22,280	0	27,934	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	WOUND CARE	0	15,230	3,408	18,638	23	76.00
76.97	07697	CARDIAC REHABILITATION	829	12,383	0	13,212	24	76.97
76.98	07698	SLEEP LAB	0	1,763	6,098	7,861	10	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,086	14,921	6,370	29,377	57	90.00
90.01	09001	ONCOLOGY CLINIC	2,747	10,647	11,093	24,487	16	90.01
91.00	09100	EMERGENCY	3,261	113,182	40,201	156,644	195	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,282,118	1,488,652	927,722	3,698,492	1,477	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18	8,267	20	8,305	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,410	136,406	12,777	159,593	24	192.00
194.00	07950	OTHER NONALLOWABLE	10,663	1,234	13,224	25,121	8	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,303,209	1,634,559	953,743	3,891,511	1,509	202.00

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		Cost Center Description	ADMITTING	PATIENT ACCOUNTING	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			5.01	5.02	5.03	6.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	37,123					5.01
5.02	00540	PATIENT ACCOUNTING	0	9,793				5.02
5.03	00550	ADMINISTRATIVE & GENERAL	0	0	1,396,318			5.03
6.00	00600	MAINTENANCE & REPAIRS	0	0	7,127	7,130		6.00
7.00	00700	OPERATION OF PLANT	0	0	91,437	1,684	468,768	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	4,298	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	29,709	148	12,765	9.00
10.00	01000	DIETARY	0	0	18,117	406	34,940	10.00
11.00	01100	CAFETERIA	0	0	16,371	133	11,422	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	41,880	32	2,724	13.00
15.00	01500	PHARMACY	0	0	41,224	85	7,278	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	20,287	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,101	290	108,808	847	72,966	30.00
43.00	04300	NURSERY	67	18	6,934	40	3,405	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,733	721	146,708	672	57,851	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	468	123	47,871	202	17,416	52.00
53.00	05300	ANESTHESIOLOGY	1,592	420	3,750	14	1,199	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,530	404	45,840	235	20,244	54.00
54.01	05401	ULTRASOUND	1,495	394	20,267	17	1,428	54.01
54.02	05402	NUCLEAR MEDICINE	540	142	10,956	30	2,550	54.02
57.00	05700	CT SCAN	5,342	1,410	17,712	24	2,062	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,755	463	12,764	77	6,590	58.00
60.00	06000	LABORATORY	4,894	1,292	103,700	214	18,437	60.00
64.00	06400	INTRAVENOUS THERAPY	834	220	18,622	138	11,875	64.00
65.00	06500	RESPIRATORY THERAPY	919	242	27,332	185	15,969	65.00
66.00	06600	PHYSICAL THERAPY	1,423	375	40,649	220	18,902	66.00
67.00	06700	OCCUPATIONAL THERAPY	77	20	2,981	12	1,025	67.00
68.00	06800	SPEECH PATHOLOGY	5	1	356	1	70	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	564	149	15,495	114	9,782	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	850	224	18,377	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,700	1,504	210,852	0	0	73.00
76.00	03020	WOUND CARE	286	75	36,206	78	6,686	76.00
76.97	07697	CARDIAC REHABILITATION	145	38	11,904	63	5,436	76.97
76.98	07698	SLEEP LAB	252	67	5,808	9	774	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,227	324	32,445	76	6,551	90.00
90.01	09001	ONCOLOGY CLINIC	134	35	12,121	54	4,674	90.01
91.00	09100	EMERGENCY	3,190	842	133,701	577	49,690	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,123	9,793	1,362,609	6,387	404,711	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,155	42	3,629	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	18,810	695	59,886	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	12,744	6	542	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	37,123	9,793	1,396,318	7,130	468,768	202.00

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		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,708					8.00
9.00	00900	HOUSEKEEPING	0	75,797				9.00
10.00	01000	DIETARY	0	0	135,332			10.00
11.00	01100	CAFETERIA	0	0	0	55,322		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	3,066	95,256	13.00
15.00	01500	PHARMACY	0	0	0	2,100	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,595	12,225	135,332	10,083	33,288	30.00
43.00	04300	NURSERY	109	1,577	0	473	1,560	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,601	13,688	0	5,890	19,448	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	761	11,051	0	3,311	10,932	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	231	1,010	0	3,645	0	54.00
54.01	05401	ULTRASOUND	109	454	0	870	0	54.01
54.02	05402	NUCLEAR MEDICINE	110	472	0	355	0	54.02
57.00	05700	CT SCAN	232	276	0	380	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	271	556	0	380	0	58.00
60.00	06000	LABORATORY	137	1,043	0	4,618	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,894	0	64.00
65.00	06500	RESPIRATORY THERAPY	178	0	0	2,057	0	65.00
66.00	06600	PHYSICAL THERAPY	309	4,074	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	17	222	0	135	0	67.00
68.00	06800	SPEECH PATHOLOGY	1	15	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	WOUND CARE	118	1,337	0	1,371	4,528	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	814	2,686	76.97
76.98	07698	SLEEP LAB	155	738	0	462	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	241	3,183	0	3,581	0	90.00
90.01	09001	ONCOLOGY CLINIC	0	0	0	753	0	90.01
91.00	09100	EMERGENCY	1,293	13,312	0	6,910	22,814	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,468	65,233	135,332	53,148	95,256	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	240	10,564	0	1,819	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	355	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	10,708	75,797	135,332	55,322	95,256	202.00

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		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY	162,844					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,882				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	769	0	576,496	0	30.00
43.00	04300	NURSERY	0	47	0	26,412	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,910	0	661,576	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	327	0	163,134	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,113	0	41,316	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,070	0	257,472	0	54.00
54.01	05401	ULTRASOUND	0	1,045	0	97,462	0	54.01
54.02	05402	NUCLEAR MEDICINE	0	377	0	59,110	0	54.02
57.00	05700	CT SCAN	0	3,735	0	35,880	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,227	0	39,520	0	58.00
60.00	06000	LABORATORY	0	3,422	0	208,555	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	583	0	61,252	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	642	0	140,169	0	65.00
66.00	06600	PHYSICAL THERAPY	0	995	0	119,864	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	54	0	6,884	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4	0	612	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	394	0	54,432	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	594	0	20,045	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	162,844	3,914	0	384,814	0	73.00
76.00	03020	WOUND CARE	0	200	0	69,546	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	102	0	34,424	0	76.97
76.98	07698	SLEEP LAB	0	176	0	16,312	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	858	0	77,920	0	90.00
90.01	09001	ONCOLOGY CLINIC	0	94	0	42,368	0	90.01
91.00	09100	EMERGENCY	0	2,230	0	391,398	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	162,844	25,882	0	3,586,973	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	14,131	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	251,631	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	38,776	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	162,844	25,882	0	3,891,511	0	202.00

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		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00540	PATIENT ACCOUNTING			5.02
5.03	00550	ADMINISTRATIVE & GENERAL			5.03
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	576,496		30.00
43.00	04300	NURSERY	26,412		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	661,576		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	163,134		52.00
53.00	05300	ANESTHESIOLOGY	41,316		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	257,472		54.00
54.01	05401	ULTRASOUND	97,462		54.01
54.02	05402	NUCLEAR MEDICINE	59,110		54.02
57.00	05700	CT SCAN	35,880		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	39,520		58.00
60.00	06000	LABORATORY	208,555		60.00
64.00	06400	INTRAVENOUS THERAPY	61,252		64.00
65.00	06500	RESPIRATORY THERAPY	140,169		65.00
66.00	06600	PHYSICAL THERAPY	119,864		66.00
67.00	06700	OCCUPATIONAL THERAPY	6,884		67.00
68.00	06800	SPEECH PATHOLOGY	612		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	54,432		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,045		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	384,814		73.00
76.00	03020	WOUND CARE	69,546		76.00
76.97	07697	CARDIAC REHABILITATION	34,424		76.97
76.98	07698	SLEEP LAB	16,312		76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		77.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	77,920		90.00
90.01	09001	ONCOLOGY CLINIC	42,368		90.01
91.00	09100	EMERGENCY	391,398		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,586,973		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,131		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	251,631		192.00
194.00	07950	OTHER NONALLOWABLE	38,776		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	3,891,511		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 1/24/2024 11:37 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	185,462					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		940,602				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	92	688	14,077,133			4.00
5.01	00570	ADMITTING	3,883	858	0	171,659,468		5.01
5.02	00540	PATIENT ACCOUNTING	231	0	0	0	171,659,468	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	22,586	139,271	846,130	0	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	0	27,053	0	0	6.00
7.00	00700	OPERATION OF PLANT	37,521	35,198	365,810	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	3,299	0	361,973	0	0	9.00
10.00	01000	DIETARY	9,030	1,309	182,717	0	0	10.00
11.00	01100	CAFETERIA	2,952	1,340	187,153	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	704	40,485	846,403	0	0	13.00
15.00	01500	PHARMACY	1,881	3,157	603,200	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	48	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,857	22,066	2,010,296	5,095,584	5,095,584	30.00
43.00	04300	NURSERY	880	4,352	121,672	310,674	310,674	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,951	268,850	1,359,467	12,651,126	12,651,126	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,501	30,486	849,945	2,165,479	2,165,479	52.00
53.00	05300	ANESTHESIOLOGY	310	29,567	0	7,369,549	7,369,549	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,232	133,713	653,338	7,084,388	7,084,388	54.00
54.01	05401	ULTRASOUND	369	67,169	221,972	6,920,812	6,920,812	54.01
54.02	05402	NUCLEAR MEDICINE	659	37,240	90,031	2,498,700	2,498,700	54.02
57.00	05700	CT SCAN	533	0	82,751	24,733,735	24,733,735	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,703	412	94,968	8,122,700	8,122,700	58.00
60.00	06000	LABORATORY	4,765	9,235	1,012,143	22,659,173	22,659,173	60.00
64.00	06400	INTRAVENOUS THERAPY	3,069	0	350,744	3,859,135	3,859,135	64.00
65.00	06500	RESPIRATORY THERAPY	4,127	14,341	432,112	4,254,324	4,254,324	65.00
66.00	06600	PHYSICAL THERAPY	4,885	8,910	496	6,586,938	6,586,938	66.00
67.00	06700	OCCUPATIONAL THERAPY	265	0	45,317	356,661	356,661	67.00
68.00	06800	SPEECH PATHOLOGY	18	0	0	24,625	24,625	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,528	0	0	2,610,291	2,610,291	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,936,974	3,936,974	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,184,233	26,184,233	73.00
76.00	03020	WOUND CARE	1,728	3,361	217,162	1,324,046	1,324,046	76.00
76.97	07697	CARDIAC REHABILITATION	1,405	0	222,694	673,121	673,121	76.97
76.98	07698	SLEEP LAB	200	6,014	90,932	1,168,735	1,168,735	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,693	6,282	530,976	5,680,733	5,680,733	90.00
90.01	09001	ONCOLOGY CLINIC	1,208	10,940	145,136	620,046	620,046	90.01
91.00	09100	EMERGENCY	12,842	39,647	1,820,124	14,767,686	14,767,686	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	168,907	914,939	13,772,715	171,659,468	171,659,468	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	938	20	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,477	12,601	227,433	0	0	192.00
194.00	07950	OTHER NONALLOWABLE	140	13,042	76,985	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,634,559	953,743	2,952,619	226,694	727,692	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.813444	1.013971	0.209746	0.001321	0.004239	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			1,509	37,123	9,793	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000107	0.000216	0.000057	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: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 1/24/2024 11:37 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5A.03	5.03	6.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL	-6,575,354	35,453,395				5.03
6.00	00600	MAINTENANCE & REPAIRS	0	180,947	158,670			6.00
7.00	00700	OPERATION OF PLANT	0	2,321,615	37,521	121,149		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	109,127	0	0	185,521	8.00
9.00	00900	HOUSEKEEPING	0	754,315	3,299	3,299	0	9.00
10.00	01000	DIETARY	0	459,998	9,030	9,030	0	10.00
11.00	01100	CAFETERIA	0	415,666	2,952	2,952	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,063,342	704	704	0	13.00
15.00	01500	PHARMACY	0	1,046,682	1,881	1,881	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	515,107	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,762,670	18,857	18,857	79,617	30.00
43.00	04300	NURSERY	0	176,064	880	880	1,882	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,724,979	14,951	14,951	27,745	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,215,452	4,501	4,501	13,182	52.00
53.00	05300	ANESTHESIOLOGY	0	95,213	310	310	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,163,892	5,232	5,232	4,001	54.00
54.01	05401	ULTRASOUND	0	514,599	369	369	1,885	54.01
54.02	05402	NUCLEAR MEDICINE	0	278,179	659	659	1,901	54.02
57.00	05700	CT SCAN	0	449,709	533	533	4,017	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	324,084	1,703	1,703	4,703	58.00
60.00	06000	LABORATORY	0	2,632,976	4,765	4,765	2,370	60.00
64.00	06400	INTRAVENOUS THERAPY	0	472,816	3,069	3,069	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	693,965	4,127	4,127	3,088	65.00
66.00	06600	PHYSICAL THERAPY	0	1,032,100	4,885	4,885	5,353	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	75,687	265	265	290	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,040	18	18	20	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	393,419	2,528	2,528	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	466,605	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,354,035	0	0	0	73.00
76.00	03020	WOUND CARE	0	919,277	1,728	1,728	2,038	76.00
76.97	07697	CARDIAC REHABILITATION	0	302,237	1,405	1,405	0	76.97
76.98	07698	SLEEP LAB	0	147,474	200	200	2,686	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	823,785	1,693	1,693	4,184	90.00
90.01	09001	ONCOLOGY CLINIC	0	307,746	1,208	1,208	0	90.01
91.00	09100	EMERGENCY	0	3,394,718	12,842	12,842	22,397	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,575,354	34,597,520	142,115	104,594	181,359	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	54,710	938	938	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	477,581	15,477	15,477	4,162	192.00
194.00	07950	OTHER NONALLOWABLE	0	323,584	140	140	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		6,575,354	214,506	2,802,918	129,366	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.185465	1.351900	23.136122	0.697312	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		1,396,318	7,130	468,768	10,708	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.039385	0.044936	3.869351	0.057719	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

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		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	20,857					9.00
10.00	01000	DIETARY	0	27,723				10.00
11.00	01100	CAFETERIA	0	0	15,572			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	863	8,121		13.00
15.00	01500	PHARMACY	0	0	591	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,364	27,723	2,838	2,838	0	30.00
43.00	04300	NURSERY	434	0	133	133	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,766	0	1,658	1,658	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,041	0	932	932	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	278	0	1,026	0	0	54.00
54.01	05401	ULTRASOUND	125	0	245	0	0	54.01
54.02	05402	NUCLEAR MEDICINE	130	0	100	0	0	54.02
57.00	05700	CT SCAN	76	0	107	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	153	0	107	0	0	58.00
60.00	06000	LABORATORY	287	0	1,300	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	533	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	579	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,121	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	61	0	38	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
76.00	03020	WOUND CARE	368	0	386	386	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	229	229	0	76.97
76.98	07698	SLEEP LAB	203	0	130	0	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	876	0	1,008	0	0	90.00
90.01	09001	ONCOLOGY CLINIC	0	0	212	0	0	90.01
91.00	09100	EMERGENCY	3,663	0	1,945	1,945	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,950	27,723	14,960	8,121	100	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	2,907	0	512	0	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	100	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	975,000	766,439	565,046	1,309,110	1,308,312	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	46.746896	27.646323	36.286026	161.200591	13,083.120000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	75,797	135,332	55,322	95,256	162,844	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.634128	4.881578	3.552659	11.729590	1,628.440000	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

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		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)		
			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
5.01	00570	ADMITTING				5.01
5.02	00540	PATIENT ACCOUNTING				5.02
5.03	00550	ADMINISTRATIVE & GENERAL				5.03
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	171,659,468			16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	5,095,584	0		30.00
43.00	04300	NURSERY	310,674	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	12,651,126	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,165,479	0		52.00
53.00	05300	ANESTHESIOLOGY	7,369,549	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,084,388	0		54.00
54.01	05401	ULTRASOUND	6,920,812	0		54.01
54.02	05402	NUCLEAR MEDICINE	2,498,700	0		54.02
57.00	05700	CT SCAN	24,733,735	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,122,700	0		58.00
60.00	06000	LABORATORY	22,659,173	0		60.00
64.00	06400	INTRAVENOUS THERAPY	3,859,135	0		64.00
65.00	06500	RESPIRATORY THERAPY	4,254,324	0		65.00
66.00	06600	PHYSICAL THERAPY	6,586,938	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	356,661	0		67.00
68.00	06800	SPEECH PATHOLOGY	24,625	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,610,291	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,936,974	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,184,233	0		73.00
76.00	03020	WOUND CARE	1,324,046	0		76.00
76.97	07697	CARDIAC REHABILITATION	673,121	0		76.97
76.98	07698	SLEEP LAB	1,168,735	0		76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	5,680,733	0		90.00
90.01	09001	ONCOLOGY CLINIC	620,046	0		90.01
91.00	09100	EMERGENCY	14,767,686	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	171,659,468	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OTHER NONALLOWABLE	0	0		194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	610,641	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.003557	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	25,882	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000151	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 1/24/2024 11:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,294,626		5,294,626	0	0	30.00
43.00	04300	NURSERY	279,239		279,239	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,349,781		5,349,781	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,894,207		1,894,207	0	0	52.00
53.00	05300	ANESTHESIOLOGY	146,676		146,676	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,586,088		1,586,088	0	0	54.00
54.01	05401	ULTRASOUND	659,739		659,739	0	0	54.01
54.02	05402	NUCLEAR MEDICINE	365,829		365,829	0	0	54.02
57.00	05700	CT SCAN	644,382		644,382	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	469,099		469,099	0	0	58.00
60.00	06000	LABORATORY	3,380,827		3,380,827	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	668,728		668,728	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	962,029	0	962,029	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,422,708	0	1,422,708	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	101,915	0	101,915	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,446	0	11,446	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	537,575		537,575	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	567,148		567,148	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,748,509		7,748,509	0	0	73.00
76.00	03020	WOUND CARE	1,231,649		1,231,649	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	440,314		440,314	0	0	76.97
76.98	07698	SLEEP LAB	199,959		199,959	0	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,118,676		1,118,676	0	0	90.00
90.01	09001	ONCOLOGY CLINIC	404,302		404,302	0	0	90.01
91.00	09100	EMERGENCY	4,962,286		4,962,286	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	836,609		836,609		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	41,284,346	0	41,284,346	0	0	200.00
201.00		Less Observation Beds	836,609		836,609		0	201.00
202.00		Total (see instructions)	40,447,737	0	40,447,737	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 1/24/2024 11:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,864,664		3,864,664			30.00
43.00	04300	NURSERY	310,674		310,674			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,028,615	11,622,511	12,651,126	0.422870	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,341,817	823,662	2,165,479	0.874729	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	571,321	6,798,228	7,369,549	0.019903	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	278,890	6,805,498	7,084,388	0.223885	0.000000	54.00
54.01	05401	ULTRASOUND	413,169	6,507,643	6,920,812	0.095327	0.000000	54.01
54.02	05402	NUCLEAR MEDICINE	45,873	2,452,827	2,498,700	0.146408	0.000000	54.02
57.00	05700	CT SCAN	1,060,949	23,672,786	24,733,735	0.026053	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	281,238	7,841,462	8,122,700	0.057752	0.000000	58.00
60.00	06000	LABORATORY	3,566,040	19,093,133	22,659,173	0.149203	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	313,989	3,545,146	3,859,135	0.173284	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,020,619	3,233,705	4,254,324	0.226130	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	389,761	6,197,177	6,586,938	0.215989	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	202,293	154,368	356,661	0.285748	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	14,345	10,280	24,625	0.464812	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	722,574	1,887,717	2,610,291	0.205944	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	300,581	3,636,393	3,936,974	0.144057	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,215,365	23,968,868	26,184,233	0.295923	0.000000	73.00
76.00	03020	WOUND CARE	3,718	1,320,328	1,324,046	0.930216	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	673,121	673,121	0.654138	0.000000	76.97
76.98	07698	SLEEP LAB	0	1,168,735	1,168,735	0.171090	0.000000	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,808	5,676,925	5,680,733	0.196925	0.000000	90.00
90.01	09001	ONCOLOGY CLINIC	375	619,671	620,046	0.652052	0.000000	90.01
91.00	09100	EMERGENCY	310,380	14,457,306	14,767,686	0.336023	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	83,422	1,147,498	1,230,920	0.679662	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	18,344,480	153,314,988	171,659,468			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	18,344,480	153,314,988	171,659,468			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 1/24/2024 11:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
54.02	05402	NUCLEAR MEDICINE	0.000000		54.02
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	WOUND CARE	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	SLEEP LAB	0.000000		76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	ONCOLOGY CLINIC	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
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: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 1/24/2024 11:37 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,294,626		5,294,626	0	5,294,626	30.00
43.00	04300	NURSERY	279,239		279,239	0	279,239	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,349,781		5,349,781	0	5,349,781	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,894,207		1,894,207	0	1,894,207	52.00
53.00	05300	ANESTHESIOLOGY	146,676		146,676	0	146,676	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,586,088		1,586,088	0	1,586,088	54.00
54.01	05401	ULTRASOUND	659,739		659,739	0	659,739	54.01
54.02	05402	NUCLEAR MEDICINE	365,829		365,829	0	365,829	54.02
57.00	05700	CT SCAN	644,382		644,382	0	644,382	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	469,099		469,099	0	469,099	58.00
60.00	06000	LABORATORY	3,380,827		3,380,827	0	3,380,827	60.00
64.00	06400	INTRAVENOUS THERAPY	668,728		668,728	0	668,728	64.00
65.00	06500	RESPIRATORY THERAPY	962,029	0	962,029	0	962,029	65.00
66.00	06600	PHYSICAL THERAPY	1,422,708	0	1,422,708	0	1,422,708	66.00
67.00	06700	OCCUPATIONAL THERAPY	101,915	0	101,915	0	101,915	67.00
68.00	06800	SPEECH PATHOLOGY	11,446	0	11,446	0	11,446	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	537,575		537,575	0	537,575	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	567,148		567,148	0	567,148	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,748,509		7,748,509	0	7,748,509	73.00
76.00	03020	WOUND CARE	1,231,649		1,231,649	0	1,231,649	76.00
76.97	07697	CARDIAC REHABILITATION	440,314		440,314	0	440,314	76.97
76.98	07698	SLEEP LAB	199,959		199,959	0	199,959	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,118,676		1,118,676	0	1,118,676	90.00
90.01	09001	ONCOLOGY CLINIC	404,302		404,302	0	404,302	90.01
91.00	09100	EMERGENCY	4,962,286		4,962,286	0	4,962,286	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	836,609		836,609		836,609	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	41,284,346	0	41,284,346	0	41,284,346	200.00
201.00		Less Observation Beds	836,609		836,609		836,609	201.00
202.00		Total (see instructions)	40,447,737	0	40,447,737	0	40,447,737	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 1/24/2024 11:37 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,864,664		3,864,664			30.00
43.00	04300	NURSERY	310,674		310,674			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,028,615	11,622,511	12,651,126	0.422870	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,341,817	823,662	2,165,479	0.874729	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	571,321	6,798,228	7,369,549	0.019903	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	278,890	6,805,498	7,084,388	0.223885	0.000000	54.00
54.01	05401	ULTRASOUND	413,169	6,507,643	6,920,812	0.095327	0.000000	54.01
54.02	05402	NUCLEAR MEDICINE	45,873	2,452,827	2,498,700	0.146408	0.000000	54.02
57.00	05700	CT SCAN	1,060,949	23,672,786	24,733,735	0.026053	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	281,238	7,841,462	8,122,700	0.057752	0.000000	58.00
60.00	06000	LABORATORY	3,566,040	19,093,133	22,659,173	0.149203	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	313,989	3,545,146	3,859,135	0.173284	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,020,619	3,233,705	4,254,324	0.226130	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	389,761	6,197,177	6,586,938	0.215989	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	202,293	154,368	356,661	0.285748	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	14,345	10,280	24,625	0.464812	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	722,574	1,887,717	2,610,291	0.205944	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	300,581	3,636,393	3,936,974	0.144057	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,215,365	23,968,868	26,184,233	0.295923	0.000000	73.00
76.00	03020	WOUND CARE	3,718	1,320,328	1,324,046	0.930216	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	673,121	673,121	0.654138	0.000000	76.97
76.98	07698	SLEEP LAB	0	1,168,735	1,168,735	0.171090	0.000000	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,808	5,676,925	5,680,733	0.196925	0.000000	90.00
90.01	09001	ONCOLOGY CLINIC	375	619,671	620,046	0.652052	0.000000	90.01
91.00	09100	EMERGENCY	310,380	14,457,306	14,767,686	0.336023	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	83,422	1,147,498	1,230,920	0.679662	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	18,344,480	153,314,988	171,659,468			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	18,344,480	153,314,988	171,659,468			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 1/24/2024 11:37 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
54.02	05402	NUCLEAR MEDICINE	0.000000		54.02
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	WOUND CARE	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	SLEEP LAB	0.000000		76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	ONCOLOGY CLINIC	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 1/24/2024 11:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	661,576	12,651,126	0.052294	312,812	16,358	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	163,134	2,165,479	0.075334	0	0	52.00
53.00	05300	ANESTHESIOLOGY	41,316	7,369,549	0.005606	176,900	992	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	257,472	7,084,388	0.036344	135,460	4,923	54.00
54.01	05401	ULTRASOUND	97,462	6,920,812	0.014082	230,514	3,246	54.01
54.02	05402	NUCLEAR MEDICINE	59,110	2,498,700	0.023656	17,400	412	54.02
57.00	05700	CT SCAN	35,880	24,733,735	0.001451	422,803	613	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	39,520	8,122,700	0.004865	143,307	697	58.00
60.00	06000	LABORATORY	208,555	22,659,173	0.009204	1,411,747	12,994	60.00
64.00	06400	INTRAVENOUS THERAPY	61,252	3,859,135	0.015872	84,556	1,342	64.00
65.00	06500	RESPIRATORY THERAPY	140,169	4,254,324	0.032947	578,896	19,073	65.00
66.00	06600	PHYSICAL THERAPY	119,864	6,586,938	0.018197	177,297	3,226	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,884	356,661	0.019301	101,000	1,949	67.00
68.00	06800	SPEECH PATHOLOGY	612	24,625	0.024853	9,934	247	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	54,432	2,610,291	0.020853	294,899	6,150	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,045	3,936,974	0.005091	166,257	846	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	384,814	26,184,233	0.014696	1,019,335	14,980	73.00
76.00	03020	WOUND CARE	69,546	1,324,046	0.052525	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	34,424	673,121	0.051141	0	0	76.97
76.98	07698	SLEEP LAB	16,312	1,168,735	0.013957	0	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	77,920	5,680,733	0.013717	744	10	90.00
90.01	09001	ONCOLOGY CLINIC	42,368	620,046	0.068330	0	0	90.01
91.00	09100	EMERGENCY	391,398	14,767,686	0.026504	21,319	565	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	91,092	1,230,920	0.074003	6,708	496	92.00
200.00		Total (lines 50 through 199)	3,075,157	167,484,130		5,311,888	89,119	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 1/24/2024 11:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	NUCLEAR MEDICINE	0	0	0	0	0	54.02
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	WOUND CARE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	SLEEP LAB	0	0	0	0	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ONCOLOGY CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 1/24/2024 11:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	12,651,126	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,165,479	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	7,369,549	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,084,388	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	6,920,812	0.000000	54.01
54.02	05402	NUCLEAR MEDICINE	0	0	0	2,498,700	0.000000	54.02
57.00	05700	CT SCAN	0	0	0	24,733,735	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	8,122,700	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	22,659,173	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,859,135	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,254,324	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,586,938	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	356,661	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	24,625	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,610,291	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,936,974	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,184,233	0.000000	73.00
76.00	03020	WOUND CARE	0	0	0	1,324,046	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	673,121	0.000000	76.97
76.98	07698	SLEEP LAB	0	0	0	1,168,735	0.000000	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	5,680,733	0.000000	90.00
90.01	09001	ONCOLOGY CLINIC	0	0	0	620,046	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	14,767,686	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,230,920	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	167,484,130		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 1/24/2024 11:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	312,812	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	176,900	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	135,460	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	230,514	0	0	0	54.01
54.02	05402	NUCLEAR MEDICINE	0.000000	17,400	0	0	0	54.02
57.00	05700	CT SCAN	0.000000	422,803	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	143,307	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,411,747	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	84,556	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	578,896	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	177,297	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	101,000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	9,934	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	294,899	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	166,257	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,019,335	0	0	0	73.00
76.00	03020	WOUND CARE	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	SLEEP LAB	0.000000	0	0	0	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	744	0	0	0	90.00
90.01	09001	ONCOLOGY CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	21,319	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	6,708	0	0	0	92.00
200.00		Total (lines 50 through 199)		5,311,888	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 1/24/2024 11:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.422870	0	3,360,166	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.874729	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.019903	0	1,780,839	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.223885	0	1,652,192	0	0	54.00
54.01	05401	ULTRASOUND	0.095327	0	2,314,166	0	0	54.01
54.02	05402	NUCLEAR MEDICINE	0.146408	0	1,045,166	0	0	54.02
57.00	05700	CT SCAN	0.026053	0	8,025,558	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.057752	0	2,376,414	0	0	58.00
60.00	06000	LABORATORY	0.149203	0	5,878,907	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.173284	0	1,470,717	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.226130	0	1,141,871	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.215989	0	1,920,593	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.285748	0	60,443	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.464812	0	4,860	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.205944	0	571,685	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.144057	0	1,196,693	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.295923	0	10,363,982	2,603	0	73.00
76.00	03020	WOUND CARE	0.930216	0	624,558	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.654138	0	352,204	0	0	76.97
76.98	07698	SLEEP LAB	0.171090	0	332,432	0	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.196925	0	1,847,201	0	0	90.00
90.01	09001	ONCOLOGY CLINIC	0.652052	0	270,222	0	0	90.01
91.00	09100	EMERGENCY	0.336023	0	4,155,756	1,008	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.679662	0	613,034	0	0	92.00
200.00		Subtotal (see instructions)		0	51,359,659	3,611	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	51,359,659	3,611	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 1/24/2024 11:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,420,913	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	35,444	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	369,901	0		54.00
54.01	05401	ULTRASOUND	220,603	0		54.01
54.02	05402	NUCLEAR MEDICINE	153,021	0		54.02
57.00	05700	CT SCAN	209,090	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	137,243	0		58.00
60.00	06000	LABORATORY	877,151	0		60.00
64.00	06400	INTRAVENOUS THERAPY	254,852	0		64.00
65.00	06500	RESPIRATORY THERAPY	258,211	0		65.00
66.00	06600	PHYSICAL THERAPY	414,827	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	17,271	0		67.00
68.00	06800	SPEECH PATHOLOGY	2,259	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	117,735	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	172,392	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,066,941	770		73.00
76.00	03020	WOUND CARE	580,974	0		76.00
76.97	07697	CARDIAC REHABILITATION	230,390	0		76.97
76.98	07698	SLEEP LAB	56,876	0		76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	363,760	0		90.00
90.01	09001	ONCOLOGY CLINIC	176,199	0		90.01
91.00	09100	EMERGENCY	1,396,430	339		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	416,656	0		92.00
200.00		Subtotal (see instructions)	10,949,139	1,109		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	10,949,139	1,109		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 1/24/2024 11:37 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,938	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,561	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,944	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	169	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)	169	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	20	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)	19	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,521	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)	136	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)	115	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	201.56	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	201.56	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,294,626	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)	4,031	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)	3,830	25.00
26.00	Total swing-bed cost (see instructions)	466,165	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,828,461	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)	4,828,461	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)	1,355.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,062,370	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)	2,062,370	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 1/24/2024 11:37 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,036,104	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)	3,098,474	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	184,406	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	155,932	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	340,338	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)	617	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,355.93	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1350	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 1/24/2024 11:37 am
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	836,609	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	576,496	5,294,626	0.108883	836,609	91,092	90.00
91.00	Nursing Program cost	0	5,294,626	0.000000	836,609	0	91.00
92.00	Allied health cost	0	5,294,626	0.000000	836,609	0	92.00
93.00	All other Medical Education	0	5,294,626	0.000000	836,609	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 1/24/2024 11:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,055,244		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.422870	312,812	132,279	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.874729	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.019903	176,900	3,521	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.223885	135,460	30,327	54.00
54.01	05401	ULTRASOUND	0.095327	230,514	21,974	54.01
54.02	05402	NUCLEAR MEDICINE	0.146408	17,400	2,547	54.02
57.00	05700	CT SCAN	0.026053	422,803	11,015	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.057752	143,307	8,276	58.00
60.00	06000	LABORATORY	0.149203	1,411,747	210,637	60.00
64.00	06400	INTRAVENOUS THERAPY	0.173284	84,556	14,652	64.00
65.00	06500	RESPIRATORY THERAPY	0.226130	578,896	130,906	65.00
66.00	06600	PHYSICAL THERAPY	0.215989	177,297	38,294	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.285748	101,000	28,861	67.00
68.00	06800	SPEECH PATHOLOGY	0.464812	9,934	4,617	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.205944	294,899	60,733	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.144057	166,257	23,950	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.295923	1,019,335	301,645	73.00
76.00	03020	WOUND CARE	0.930216	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.654138	0	0	76.97
76.98	07698	SLEEP LAB	0.171090	0	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.196925	744	147	90.00
90.01	09001	ONCOLOGY CLINIC	0.652052	0	0	90.01
91.00	09100	EMERGENCY	0.336023	21,319	7,164	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.679662	6,708	4,559	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,311,888	1,036,104	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)		5,311,888		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1350 | Component CCN: 14-Z350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 1/24/2024 11:37 am

Title XVIII | Swing Beds - SNF | 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				30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.422870	3,543	1,498	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.874729	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.019903	3,466	69	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.223885	6,187	1,385	54.00
54.01	05401	ULTRASOUND	0.095327	4,914	468	54.01
54.02	05402	NUCLEAR MEDICINE	0.146408	0	0	54.02
57.00	05700	CT SCAN	0.026053	2,389	62	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.057752	0	0	58.00
60.00	06000	LABORATORY	0.149203	81,265	12,125	60.00
64.00	06400	INTRAVENOUS THERAPY	0.173284	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.226130	55,135	12,468	65.00
66.00	06600	PHYSICAL THERAPY	0.215989	81,566	17,617	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.285748	34,391	9,827	67.00
68.00	06800	SPEECH PATHOLOGY	0.464812	2,199	1,022	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.205944	24,946	5,137	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.144057	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.295923	129,910	38,443	73.00
76.00	03020	WOUND CARE	0.930216	1,827	1,700	76.00
76.97	07697	CARDIAC REHABILITATION	0.654138	0	0	76.97
76.98	07698	SLEEP LAB	0.171090	0	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.196925	0	0	90.00
90.01	09001	ONCOLOGY CLINIC	0.652052	0	0	90.01
91.00	09100	EMERGENCY	0.336023	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.679662	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		431,738	101,821	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)		431,738		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1350 | Component CCN: 14-Z350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 1/24/2024 11:37 am

Title XIX | Swing Beds - SNF | 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				30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.422870	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.874729	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.019903	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.223885	0	0	54.00
54.01	05401	ULTRASOUND	0.095327	0	0	54.01
54.02	05402	NUCLEAR MEDICINE	0.146408	0	0	54.02
57.00	05700	CT SCAN	0.026053	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.057752	0	0	58.00
60.00	06000	LABORATORY	0.149203	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.173284	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.226130	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.215989	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.285748	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.464812	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.205944	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.144057	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.295923	0	0	73.00
76.00	03020	WOUND CARE	0.930216	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.654138	0	0	76.97
76.98	07698	SLEEP LAB	0.171090	0	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.196925	0	0	90.00
90.01	09001	ONCOLOGY CLINIC	0.652052	0	0	90.01
91.00	09100	EMERGENCY	0.336023	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.679662	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1350	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 1/24/2024 11:37 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	10,950,248	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	10,950,248	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)	11,059,750	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)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	135,162	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	9,053,936	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,870,652	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	1,870,652	30.00
31.00	Primary payer payments	11	31.00
32.00	Subtotal (line 30 minus line 31)	1,870,641	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)	1,354,757	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	880,592	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	952,262	36.00
37.00	Subtotal (see instructions)	2,751,233	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,751,233	40.00
40.01	Sequestration adjustment (see instructions)	55,025	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	2,453,861	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)	242,347	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1350	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 1/24/2024 11:37 am
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 1/24/2024 11:37 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,204,255		2,932,441	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	03/01/2023	65,079	03/01/2023	106,888	3.50
3.51		06/23/2023	27,258	06/23/2023	371,692	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)		-92,337		-478,580	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)		3,111,918		2,453,861	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		242,347	6.01
6.02	SETTLEMENT TO PROGRAM		449,551		0	6.02
7.00	Total Medicare program liability (see instructions)		2,662,367		2,696,208	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1350 | Component CCN: 14-Z350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 1/24/2024 11:37 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		356,785		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	03/01/2023	55,137		0	3.01
3.02		06/23/2023	15,077		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)		70,214		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)		426,999		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		7,409		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		434,408		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1350	Period: From 07/01/2022 To 06/30/2023	Worksheet E-1 Part II Date/Time Prepared: 1/24/2024 11:37 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 14-1350 Component CCN: 14-Z350	Period: From 07/01/2022 To 06/30/2023	Worksheet E-2 Date/Time Prepared: 1/24/2024 11:37 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	343,741	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	102,839	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	251	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	446,580	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	446,580	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	446,580	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,307	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	443,273	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	443,273	0	19.00
19.01	Sequestration adjustment (see instructions)	8,865	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	426,999	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	7,409	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 14-1350 Component CCN: 14-Z350	Period: From 07/01/2022 To 06/30/2023	Worksheet E-2 Date/Time Prepared: 1/24/2024 11:37 am
	Title XIX	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0		3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (see instructions)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0		19.25
20.00	Interim payments	0		20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0		21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	0		22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1350	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part V Date/Time Prepared: 1/24/2024 11:37 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,098,474	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	3,098,474	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,129,459	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,129,459	19.00
20.00	Deductibles (exclude professional component)	467,212	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,662,247	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,662,247	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	83,775	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	54,454	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	59,675	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,716,701	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,716,701	30.00
30.01	Sequestration adjustment (see instructions)	54,334	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	3,111,918	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-449,551	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G | Date/Time Prepared: 1/24/2024 11:37 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	82,084	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	15,248,106	0	0	0	4.00
5.00	Other receivable	928,678	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,728,020	0	0	0	6.00
7.00	Inventory	977,811	0	0	0	7.00
8.00	Prepaid expenses	428,287	0	0	0	8.00
9.00	Other current assets	1,248,642	0	0	0	9.00
10.00	Due from other funds	-121,041	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	11,064,547	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	462,220	0	0	0	12.00
13.00	Land improvements	1,244,575	0	0	0	13.00
14.00	Accumulated depreciation	-760,056	0	0	0	14.00
15.00	Buildings	39,323,525	0	0	0	15.00
16.00	Accumulated depreciation	-19,008,516	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	14,586,013	0	0	0	23.00
24.00	Accumulated depreciation	-10,222,034	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)	25,625,727	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	105,465,416	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	-912,071	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	104,553,345	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	141,243,619	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,033,533	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,435,379	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,391,711	0	0	0	40.00
41.00	Deferred income	32,589	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	390,101	0	0	0	43.00
44.00	Other current liabilities	1,489,523	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,772,836	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,122,951	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-304,382	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	6,818,569	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,591,405	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	127,652,214				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)	127,652,214	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	141,243,619	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-1 | Date/Time Prepared: 1/24/2024 11:37 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		110,585,891		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		17,494,931				2.00
3.00	Total (sum of line 1 and line 2)		128,080,822		0		3.00
4.00	Additions (credit adjustments) (specify)	0		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)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		128,080,822		0		11.00
12.00	TRANSFER OF ASSETS	428,608		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)		428,608		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		127,652,214		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			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	TRANSFER OF ASSETS		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: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 1/24/2024 11:37 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,045,062		4,045,062	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	124,722		124,722	5.00
6.00	Swing bed - NF	14,391		14,391	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)	4,184,175		4,184,175	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,184,175		4,184,175	17.00
18.00	Ancillary services	13,824,866	133,408,609	147,233,475	18.00
19.00	Outpatient services	407,350	22,102,319	22,509,669	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROF FEE	161,243	3,447,338	3,608,581	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	18,577,634	158,958,266	177,535,900	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		50,919,808		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)		50,919,808		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1350 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-3 | Date/Time Prepared: 1/24/2024 11:37 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	177,535,900	1.00
2.00	Less contractual allowances and discounts on patients' accounts	115,923,896	2.00
3.00	Net patient revenues (line 1 minus line 2)	61,612,004	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	50,919,808	4.00
5.00	Net income from service to patients (line 3 minus line 4)	10,692,196	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	753,865	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	1,757	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	3,837	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	62,812	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	328,580	22.00
23.00	Governmental appropriations	117,308	23.00
24.00	MISC INCOME	628,572	24.00
24.50	COVID-19 PHE Funding	159,223	24.50
25.00	Total other income (sum of lines 6-24)	2,055,954	25.00
26.00	Total (line 5 plus line 25)	12,748,150	26.00
27.00	NON-OPERATING EXPENSES	34,632	27.00
27.01	GAIN/LOSS ON ASSET DISPOSAL	12,931	27.01
27.02	PENSION	-1,927,078	27.02
27.03	NON-OPERATING LOSS	-2,867,266	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	-4,746,781	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	17,494,931	29.00