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: 14-1336	Period: From 07/01/2022 To 06/30/2023	Worksheet S Parts I-III Date/Time Prepared: 1/24/2024 11:48 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 1/24/2024 Time: 11:48 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. JOSEPHS HOSPITAL-HIGHLAND IL (14-1336) 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	-32,561	-250,111	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	152,652	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	120,091	-250,111	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 1/24/2024 11:48 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 12866 TROXLER AVENUE	PO Box:			1.00
2.00	City: HIGHLAND	State: IL	Zip Code: 62249	County: MADISON	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. JOSEPHS HOSPITAL-HIGHLAND IL	141336	41180	1	06/01/2004	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. JOSEPHS HOSPITAL-SWING BED	14Z336	41180		08/19/2004	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	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: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 1/24/2024 11:48 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.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 1/24/2024 11:48 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)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1336	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 1/24/2024 11:48 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	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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.	N	Y	N	N	109.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 1/24/2024 11:48 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	61,254	460	385,894	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	5.06	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: NATIONAL 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 1/24/2024 11:48 am

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

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

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		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: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 1/24/2024 11:48 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)	N			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: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 1/24/2024 11:48 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.	Y	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.	Y	33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1336	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part II Date/Time Prepared: 1/24/2024 11:48 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 1/24/2024 11:48 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	83,327.70	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	83,327.70	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						13.00
14.00	Total (see instructions)		25	9,125	83,327.70	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: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 1/24/2024 11:48 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)	1,458	54	3,451			1.00
2.00	HMO and other (see instructions)	1,322	153				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	1,254	0	2,445			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	245			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,712	54	6,141			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)	2,712	54	6,141	0.00	162.88	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)			59			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	162.88	27.00
28.00	Observation Bed Days		1	527			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			35			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 1/24/2024 11:48 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	404	16	999	1.00
2.00	HMO and other (see instructions)			352	44		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	404	16	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: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-10 | Date/Time Prepared: 1/24/2024 11:48 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)	0.245097	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,148,338	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	13,779,716	6.00
7.00	Medicaid cost (line 1 times line 6)	3,377,367	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)	229,029	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)	229,029	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)	968,313	291,995	1,260,308	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	237,331	291,995	529,326	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)	237,331	291,995	529,326	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,299,821	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	283,267	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	435,795	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,864,026	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	609,395	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,138,721	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,367,750	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 1/24/2024 11:48 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		2,141,919	2,141,919	1,950,080	4,091,999	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,197,824	1,197,824	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,789,852	3,789,852	0	3,789,852	4.00
5.01	01160	COMMUNICATIONS	0	8,411	8,411	1,682	10,093	5.01
5.02	00550	DATA PROCESSING	0	1,223,963	1,223,963	0	1,223,963	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	123,226	131,773	254,999	-86,582	168,417	5.03
5.04	00570	ADMITTING	0	1,517	1,517	0	1,517	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	2,220,660	2,220,660	0	2,220,660	5.05
5.06	00590	OTHER ADMIN & GENERAL	440,424	8,953,725	9,394,149	-1,096,354	8,297,795	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	234,079	941,634	1,175,713	-358	1,175,355	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	137,815	137,815	0	137,815	8.00
9.00	00900	HOUSEKEEPING	336,303	157,614	493,917	0	493,917	9.00
10.00	01000	DIETARY	302,687	462,354	765,041	0	765,041	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	780,828	28,713	809,541	0	809,541	13.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,491,357	1,418,465	3,909,822	-244,053	3,665,769	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,248,609	2,351,902	3,600,511	-1,882,378	1,718,133	50.00
53.00	05300	ANESTHESIOLOGY	0	436,237	436,237	-17,115	419,122	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	963,244	753,139	1,716,383	-178,444	1,537,939	54.00
60.00	06000	LABORATORY	805,731	1,146,165	1,951,896	-556,462	1,395,434	60.00
64.00	06400	INTRAVENOUS THERAPY	97,420	76,394	173,814	-42,911	130,903	64.00
65.00	06500	RESPIRATORY THERAPY	146,177	81,676	227,853	-50,699	177,154	65.00
65.01	06501	SLEEP LAB	169,202	55,808	225,010	-30,221	194,789	65.01
66.00	06600	PHYSICAL THERAPY	975,931	23,669	999,600	-29,119	970,481	66.00
67.00	06700	OCCUPATIONAL THERAPY	175,961	14,845	190,806	19,128	209,934	67.00
68.00	06800	SPEECH PATHOLOGY	44,534	111	44,645	3,783	48,428	68.00
68.01	03040	AUDIOLOGY	57	-1,166	-1,109	1,109	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	18,890	18,890	2,732,068	2,750,958	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	990,632	990,632	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	578,227	1,975,560	2,553,787	3,143	2,556,930	73.00
76.97	07697	CARDIAC REHABILITATION	217,897	10,738	228,635	-3,327	225,308	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	283,143	1,268,402	1,551,545	-733,617	817,928	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
91.00	09100	EMERGENCY	1,389,182	1,374,007	2,763,189	-176,131	2,587,058	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	218,429	22,411	240,840	-523	240,317	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,568,611	1,568,611	-1,568,611	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,022,648	32,795,814	44,818,462	202,544	45,021,006	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	25,434	25,434	0	25,434	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	78,089	237,503	315,592	-201,897	113,695	192.00
194.00	07950	TRANSPORTATION	34,115	17,129	51,244	-1,324	49,920	194.00
194.01	07951	FUND DEVELOPMENT	-677	0	-677	677	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	12,134,175	33,075,880	45,210,055	0	45,210,055	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 1/24/2024 11:48 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	2,352,321	6,444,320		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	718,414	1,916,238		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,173,078	1,616,774		4.00
5.01	01160	COMMUNICATIONS	0	10,093		5.01
5.02	00550	DATA PROCESSING	779,294	2,003,257		5.02
5.03	00560	PURCHASING RECEIVING AND STORES	-78,947	89,470		5.03
5.04	00570	ADMITTING	168,616	170,133		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	-1,552,455	668,205		5.05
5.06	00590	OTHER ADMIN & GENERAL	-5,248,347	3,049,448		5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	-27,627	1,147,728		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,997	139,812		8.00
9.00	00900	HOUSEKEEPING	-20,293	473,624		9.00
10.00	01000	DIETARY	-58,632	706,409		10.00
11.00	01100	CAFETERIA	-76,626	-76,626		11.00
13.00	01300	NURSING ADMINISTRATION	-362	809,179		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	456,448	456,448		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,062,254	2,603,515		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-254,925	1,463,208		50.00
53.00	05300	ANESTHESIOLOGY	-409,928	9,194		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-5,632	1,532,307		54.00
60.00	06000	LABORATORY	-891	1,394,543		60.00
64.00	06400	INTRAVENOUS THERAPY	0	130,903		64.00
65.00	06500	RESPIRATORY THERAPY	-25,493	151,661		65.00
65.01	06501	SLEEP LAB	0	194,789		65.01
66.00	06600	PHYSICAL THERAPY	-55,821	914,660		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	209,934		67.00
68.00	06800	SPEECH PATHOLOGY	0	48,428		68.00
68.01	03040	AUDIOLOGY	0	0		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	2,750,958		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	990,632		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-48,045	2,508,885		73.00
76.97	07697	CARDIAC REHABILITATION	0	225,308		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	817,928		76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-719,205	1,867,853		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	-250	240,067		93.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-7,341,721	37,679,285		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	25,434		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	113,695		192.00
194.00	07950	TRANSPORTATION	0	49,920		194.00
194.01	07951	FUND DEVELOPMENT	0	0		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-7,341,721	37,868,334		200.00

RECLASSIFICATIONS | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 1/24/2024 11:48 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAPITAL RELATED COSTS - BUILDINGS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,232,062	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	285,730	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
	0		0	1,517,792	
	B - TELEPHONE				
1.00	COMMUNICATIONS	5.01	0	1,682	1.00
2.00		0.00	0	0	2.00
	0		0	1,682	
	C - POSTAGE				
1.00	OTHER ADMIN & GENERAL	5.06	0	8,347	1.00
2.00		0.00	0	0	2.00
	0		0	8,347	
	D - INTEREST				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,568,611	1.00
	0		0	1,568,611	
	E - MED SUPPLIES - IMPLANTS				
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	2,730,305	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	990,632	2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,534	3.00
4.00	AUDIOLOGY	68.01	0	1,178	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
	0		0	3,724,649	
	F - DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	73,235	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
	0		0	73,235	
	G - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	50,785	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	10,716	2.00
	0		0	61,501	
	I - DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	901,378	1.00
	0		0	901,378	
	K - REHAB ADMIN				
1.00	OCCUPATIONAL THERAPY	67.00	17,821	1,307	1.00
2.00	SPEECH PATHOLOGY	68.00	3,628	266	2.00
	0		21,449	1,573	
	L - HEALTH CRISIS RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	4	0	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	1,763	2.00
	0		4	1,763	
	O - TO RECLASS CLOSED AUDIOLOGY DEPT				
1.00	PHYSICAL THERAPY	66.00	57	12	1.00
	TOTALS		57	12	
	P - INFUSION RECLASS				
1.00	INTRAVENOUS THERAPY	64.00	20,163	0	1.00
	0		20,163	0	

RECLASSIFICATIONS | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 1/24/2024 11:48 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	Q - NEGATIVE SALARY RECLASS				
1.00	FUND DEVELOPMENT	194.01	677	0	1.00
	TOTALS		677	0	
500.00	Grand Total: Increases		42,350	7,860,543	500.00

RECLASSIFICATIONS | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 1/24/2024 11:48 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAPITAL RELATED COSTS - BUILDINGS						
1.00	PURCHASING RECEIVING AND STORES	5.03	0	78,270	10		1.00
2.00	OTHER ADMIN & GENERAL	5.06	0	1,041,433	10		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	21,473	0		3.00
4.00	OPERATING ROOM	50.00	0	94,058	0		4.00
5.00	LABORATORY	60.00	0	3,802	0		5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	72,626	0		6.00
7.00	SLEEP LAB	65.01	0	4,233	0		7.00
8.00	PHYSICIANS PRIVATE OFFICES	192.00	0	201,897	0		8.00
	0		0	1,517,792			
	B - TELEPHONE						
1.00	OPERATION OF PLANT	7.00	0	358	0		1.00
2.00	TRANSPORTATION	194.00	0	1,324	0		2.00
	0		0	1,682			
	C - POSTAGE						
1.00	PURCHASING RECEIVING AND STORES	5.03	0	8,312	0		1.00
2.00	CARDIAC REHABILITATION	76.97	0	35	0		2.00
	0		0	8,347			
	D - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	1,568,611	11		1.00
	0		0	1,568,611			
	E - MED SUPPLIES - IMPLANTS						
1.00	ADULTS & PEDIATRICS	30.00	0	201,074	0		1.00
2.00	OPERATING ROOM	50.00	0	1,777,495	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	17,115	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	118,691	0		4.00
5.00	LABORATORY	60.00	0	552,620	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	50,691	0		6.00
7.00	INTRAVENOUS THERAPY	64.00	0	63,060	0		7.00
8.00	SLEEP LAB	65.01	0	25,988	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	6,166	0		9.00
10.00	CARDIAC REHABILITATION	76.97	0	3,292	0		10.00
11.00	HYPERBARIC OXYGEN THERAPY	76.98	0	733,612	0		11.00
12.00	EMERGENCY	91.00	0	174,211	0		12.00
13.00	O/P GERIATRIC PSYCH CENTER	93.00	0	523	0		13.00
14.00	SPEECH PATHOLOGY	68.00	0	111	0		14.00
	0		0	3,724,649			
	F - DRUGS CHARGED TO PATIENTS						
1.00	ADULTS & PEDIATRICS	30.00	0	670	0		1.00
2.00	OPERATING ROOM	50.00	0	10,825	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	59,753	0		3.00
4.00	LABORATORY	60.00	0	40	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	8	0		5.00
6.00	HYPERBARIC OXYGEN THERAPY	76.98	0	5	0		6.00
7.00	EMERGENCY	91.00	0	1,920	0		7.00
8.00	INTRAVENOUS THERAPY	64.00	0	14	0		8.00
	0		0	73,235			
	G - PROPERTY INSURANCE						
1.00	OTHER ADMIN & GENERAL	5.06	0	61,501	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	61,501			
	I - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	901,378	9		1.00
	0		0	901,378			
	K - REHAB ADMIN						
1.00	PHYSICAL THERAPY	66.00	21,449	1,573	0		1.00
2.00		0.00	0	0	0		2.00
	0		21,449	1,573			
	L - HEALTH CRISIS RECLASS						
1.00	OTHER ADMIN & GENERAL	5.06	4	1,763	0		1.00
2.00		0.00	0	0	0		2.00
	0		4	1,763			
	O - TO RECLASS CLOSED AUDIOLOGY DEPT						
1.00	AUDIOLOGY	68.01	57	12	0		1.00
	TOTALS		57	12			
	P - INFUSION RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	20,163	0	0		1.00
	0		20,163	0			
	Q - NEGATIVE SALARY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	677	0	0		1.00
	TOTALS		677	0			
500.00	Grand Total: Decreases		42,350	7,860,543			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 1/24/2024 11:48 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	2,034,874	0	0	0	0	1.00
2.00	Land Improvements	1,469,318	15,500	0	15,500	0	2.00
3.00	Buildings and Fixtures	39,696,510	131,622	0	131,622	0	3.00
4.00	Building Improvements	139,133	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	10,831,916	665,663	0	665,663	0	6.00
7.00	HIT designated Assets	9,193,721	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	63,365,472	812,785	0	812,785	0	8.00
9.00	Reconciling Items	7,079,116	-56,597	0	-56,597	358,799	9.00
10.00	Total (line 8 minus line 9)	56,286,356	869,382	0	869,382	-358,799	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,034,874	0	1.00
2.00	Land Improvements	1,484,818	0	2.00
3.00	Buildings and Fixtures	39,828,132	0	3.00
4.00	Building Improvements	139,133	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	11,497,579	0	6.00
7.00	HIT designated Assets	9,193,721	0	7.00
8.00	Subtotal (sum of lines 1-7)	64,178,257	0	8.00
9.00	Reconciling Items	6,663,720	0	9.00
10.00	Total (line 8 minus line 9)	57,514,537	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part II Date/Time Prepared: 1/24/2024 11:48 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	2,141,919	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,141,919	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	2,141,919		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	2,141,919		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 1/24/2024 11:48 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	43,486,957	0	43,486,957	0.677596	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	20,691,300	0	20,691,300	0.322404	0	2.00
3.00	Total (sum of lines 1-2)	64,178,257	0	64,178,257	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	3,677,938	1,232,062	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,619,792	285,730	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,297,730	1,517,792	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	1,483,535	50,785	0	0	6,444,320	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	10,716	0	0	1,916,238	2.00
3.00	Total (sum of lines 1-2)	1,483,535	61,501	0	0	8,360,558	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 1/24/2024 11:48 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	-85,076	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)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,061,877			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	-12,526			0	12.00
13.00	Laundry and linen service	B	0	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests	B	-76,626	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,189	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 1/24/2024 11:48 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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	23,924	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	33.00
33.01	MISCELLANEOUS INCOME	B	-78,947	PURCHASING RECEIVING AND STORES	5.03	0	33.01
33.02	MISCELLANEOUS INCOME	B	-9,388	OTHER ADMIN & GENERAL	5.06	0	33.02
33.03	MISCELLANEOUS INCOME	B	-20,640	OPERATION OF PLANT	7.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-20,293	HOUSEKEEPING	9.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-275	NURSING ADMINISTRATION	13.00	0	33.05
33.06	ATHLETICARE OTHER EXPENSE	A	-635	PHYSICAL THERAPY	66.00	0	33.06
33.07	ADVERTISING EXPENSES	A	-2,867	OTHER ADMIN & GENERAL	5.06	0	33.07
33.08	MEDICAID TAX ASSESSMENT	A	-1,430,320	OTHER ADMIN & GENERAL	5.06	0	33.08
33.09	CRNA-CONTRACT LABOR	A	-409,928	ANESTHESIOLOGY	53.00	0	33.09
33.10	PENSION ADJUSTMENT	A	-373,774	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	HSHS MED GROUP ADMIN	A	-4,044,349	OTHER ADMIN & GENERAL	5.06	0	33.11
33.12	USEFUL LIVES CARRYFORWARD ADJUSTMEN	A	111,756	CAP REL COSTS-BLDG & FIXT	1.00	9	33.12
33.13	LOBBYING EXPENSE	A	-15,725	OTHER ADMIN & GENERAL	5.06	0	33.13
33.14	COMMUNITY RELATIONS BENEFITS	A	-612	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	COMMUNITY RELATIONS SALARY	A	-4,168	OTHER ADMIN & GENERAL	5.06	0	33.15
33.16	COMMUNITY RELATIONS OTHER EXPENSE	A	-12,008	OTHER ADMIN & GENERAL	5.06	0	33.16
33.17	SELF-INSURANCE ADJUSTMENT	A	-1,634,977	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.18	PROPERTY TAX NOT RELATED TO PATIENT	A	-6,987	OPERATION OF PLANT	7.00	0	33.18
33.19	BUILDING RELIFING	A	2,325,641	CAP REL COSTS-BLDG & FIXT	1.00	9	33.19
33.20	EQUIPMENT RELIFING	A	718,414	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.20
33.21	MARKETING OTHER EXPENSE	A	-75,710	OTHER ADMIN & GENERAL	5.06	0	33.21
33.22	ALCOHOL	A	-10,789	OTHER ADMIN & GENERAL	5.06	0	33.22
33.23	ATHLETICARE BENEFITS	A	-8,092	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.23
33.24	ATHLETICARE SALARIES	A	-55,120	PHYSICAL THERAPY	66.00	0	33.24
33.25	MEALS ON WHEEL REVENUE	B	-58,632	DIETARY	10.00	0	33.25
33.26	MISCELLANEOUS INCOME	B	-5,632	RADIOLOGY-DIAGNOSTIC	54.00	0	33.26
33.27	MISCELLANEOUS INCOME	B	-66	PHYSICAL THERAPY	66.00	0	33.27
33.28	MISCELLANEOUS INCOME	B	-250	O/P GERIATRIC PSYCH CENTER	93.00	0	33.28
33.29	GIFTS OR DONATIONS MADE	A	-87	NURSING ADMINISTRATION	13.00	0	33.29
33.30	HEALTH FAIR	A	-891	LABORATORY	60.00	0	33.30
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,341,721				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: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 1/24/2024 11:48 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	2,464,036	2,467,537	1.00
2.00	5.02	DATA PROCESSING	CONTRACTED SERVICES - ISC	2,003,018	1,223,724	2.00
3.00	5.05	CASHIERING/ACCOUNTS RECEIVAB	SBO FEE	644,281	2,220,660	3.00
4.00	5.04	ADMITTING	SBO FEE	168,616	0	4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	SBO FEE	460,637	0	4.01
4.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	HR FEE	71,486	223,608	4.02
4.03	5.06	OTHER ADMIN & GENERAL	CONTRACTED SERVICES - SSC	1,354,379	805,032	4.03
4.04	5.06	OTHER ADMIN & GENERAL	PURCHASED SERVICES	0	95,584	4.04
4.05	5.06	OTHER ADMIN & GENERAL	IL - A&G	422,458	518,218	4.05
4.06	73.00	DRUGS CHARGED TO PATIENTS	IL - SHARED PHARMACIST	50,292	98,337	4.06
4.07	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	139,812	137,815	4.07
4.08	5.06	OTHER ADMIN & GENERAL	IL - LIBRARY	11,472	12,498	4.08
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,790,487	7,803,013	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		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					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: 14-1336	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-1 Date/Time Prepared: 1/24/2024 11:48 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	-3,501	0		1.00
2.00	779,294	0		2.00
3.00	-1,576,379	0		3.00
4.00	168,616	0		4.00
4.01	460,637	0		4.01
4.02	-152,122	0		4.02
4.03	549,347	0		4.03
4.04	-95,584	0		4.04
4.05	-95,760	0		4.05
4.06	-48,045	0		4.06
4.07	1,997	0		4.07
4.08	-1,026	0		4.08
5.00	-12,526			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			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: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 1/24/2024 11:48 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,062,254	1,062,254	0	0	0	1.00
2.00	91.00	EMERGENCY	1,020,562	719,205	301,357	0	0	2.00
3.00	91.00	EMERGENCY	96,000	0	96,000	0	0	3.00
4.00	76.98	HYPERBARIC OXYGEN THERAPY	25,000	0	25,000	0	0	4.00
5.00	64.00	INTRAVENOUS THERAPY	5,788	0	5,788	0	0	5.00
6.00	50.00	OPERATING ROOM	254,925	254,925	0	0	0	6.00
7.00	93.00	O/P GERIATRIC PSYCH CENTER	19,750	0	19,750	0	0	7.00
8.00	60.00	LABORATORY	55,158	0	55,158	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	28,693	25,493	3,200	0	0	9.00
10.00	76.97	CARDIAC REHABILITATION	3,313	0	3,313	0	0	10.00
200.00			2,571,443	2,061,877	509,566		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	76.98	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	4.00
5.00	64.00	INTRAVENOUS THERAPY	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	93.00	O/P GERIATRIC PSYCH CENTER	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	0	0	0	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	9.00
10.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,062,254		1.00
2.00	91.00	EMERGENCY	0	0	0	719,205		2.00
3.00	91.00	EMERGENCY	0	0	0	0		3.00
4.00	76.98	HYPERBARIC OXYGEN THERAPY	0	0	0	0		4.00
5.00	64.00	INTRAVENOUS THERAPY	0	0	0	0		5.00
6.00	50.00	OPERATING ROOM	0	0	0	254,925		6.00
7.00	93.00	O/P GERIATRIC PSYCH CENTER	0	0	0	0		7.00
8.00	60.00	LABORATORY	0	0	0	0		8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	25,493		9.00
10.00	76.97	CARDIAC REHABILITATION	0	0	0	0		10.00
200.00			0	0	0	2,061,877		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1336	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 1/24/2024 11:48 am

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		19	1.00
2.00	Line 1 multiplied by 15 hours per week		285	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		5.62	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	470.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	90.20	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)	45.10	45.10	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)	42,394	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)	42,394	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)	42,394	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)	42,394	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: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 1/24/2024 11:48 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	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)		42,394	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)		42,394	63.00
64.00	Total cost of outside supplier services (from your records)		14,326	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: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 1/24/2024 11:48 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	6,444,320	6,444,320				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,916,238		1,916,238			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,616,774	38,903	1,622	1,657,299		4.00
5.01	01160	COMMUNICATIONS	10,093	5,576	34,571	0	50,240	5.01
5.02	00550	DATA PROCESSING	2,003,257	99,044	409,955	0	5,712	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	89,470	179,733	4,478	16,830	1,166	5.03
5.04	00570	ADMITTING	170,133	57,071	1,353	0	2,331	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	668,205	85,199	388	0	583	5.05
5.06	00590	OTHER ADMIN & GENERAL	3,049,448	502,613	29,732	60,153	9,671	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,147,728	318,119	60,910	31,971	816	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	139,812	6,265	0	0	0	8.00
9.00	00900	HOUSEKEEPING	473,624	128,300	1,484	45,933	117	9.00
10.00	01000	DIETARY	706,409	164,572	4,915	41,341	233	10.00
11.00	01100	CAFETERIA	-76,626	151,605	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	809,179	46,484	99,810	106,646	117	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	456,448	75,614	641	0	1,632	16.00
17.00	01700	SOCIAL SERVICE	0	19,295	0	0	117	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,603,515	1,091,054	89,396	337,427	7,577	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,463,208	663,802	860,427	170,536	4,313	50.00
53.00	05300	ANESTHESIOLOGY	9,194	0	1,308	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,532,307	510,506	46,915	131,561	2,215	54.00
60.00	06000	LABORATORY	1,394,543	196,647	37,525	110,048	2,914	60.00
64.00	06400	INTRAVENOUS THERAPY	130,903	60,955	3,473	16,060	0	64.00
65.00	06500	RESPIRATORY THERAPY	151,661	53,813	21,361	19,965	0	65.00
65.01	06501	SLEEP LAB	194,789	76,303	16,063	23,110	933	65.01
66.00	06600	PHYSICAL THERAPY	914,660	322,880	16,048	130,372	2,098	66.00
67.00	06700	OCCUPATIONAL THERAPY	209,934	60,955	1,418	26,467	117	67.00
68.00	06800	SPEECH PATHOLOGY	48,428	0	465	6,578	0	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,750,958	105,309	6,078	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	990,632	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,508,885	73,672	2,396	78,975	1,049	73.00
76.97	07697	CARDIAC REHABILITATION	225,308	94,220	11,570	29,761	1,166	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	817,928	215,629	4,258	38,672	1,166	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
91.00	09100	EMERGENCY	1,867,853	450,929	90,872	189,736	2,331	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	240,067	155,050	41,182	29,833	933	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,679,285	6,010,117	1,900,614	1,641,975	49,307	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	25,434	48,802	4,016	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	113,695	355,769	9,104	10,665	933	192.00
194.00	07950	TRANSPORTATION	49,920	0	2,504	4,659	0	194.00
194.01	07951	FUND DEVELOPMENT	0	29,632	0	0	0	194.01
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)	37,868,334	6,444,320	1,916,238	1,657,299	50,240	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 1/24/2024 11:48 am

		Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
		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	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING	2,517,968					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	70,903	362,580				5.03
5.04	00570	ADMITTING	319,973	2,541	553,402			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	16,362	0	0	770,737		5.05
5.06	00590	OTHER ADMIN & GENERAL	279,976	26,963	0	0	3,958,556	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	27,270	95,099	0	0	1,681,913	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	146,077	8.00
9.00	00900	HOUSEKEEPING	3,636	25,243	0	0	678,337	9.00
10.00	01000	DIETARY	0	1,363	0	0	918,833	10.00
11.00	01100	CAFETERIA	0	0	0	0	74,979	11.00
13.00	01300	NURSING ADMINISTRATION	1,818	117	0	0	1,064,171	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	43,633	0	0	0	577,968	16.00
17.00	01700	SOCIAL SERVICE	12,726	0	0	0	32,138	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	245,434	43,946	127,415	33,593	4,579,357	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	98,173	21,025	23,423	56,736	3,361,643	50.00
53.00	05300	ANESTHESIOLOGY	0	4,327	9,353	15,436	39,618	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	185,439	6,715	74,795	224,927	2,715,380	54.00
60.00	06000	LABORATORY	67,267	19,410	116,298	142,864	2,087,516	60.00
64.00	06400	INTRAVENOUS THERAPY	52,723	3,943	2,721	4,576	275,354	64.00
65.00	06500	RESPIRATORY THERAPY	16,362	162	51,765	25,526	340,615	65.00
65.01	06501	SLEEP LAB	0	22,610	0	10,990	344,798	65.01
66.00	06600	PHYSICAL THERAPY	90,901	13,085	22,913	24,761	1,537,718	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,908	0	10,595	4,485	324,879	67.00
68.00	06800	SPEECH PATHOLOGY	3,636	0	876	920	60,903	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	20,832	14,318	2,897,495	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	6,748	15,186	1,012,566	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	529,048	626	67,773	89,168	3,351,592	73.00
76.97	07697	CARDIAC REHABILITATION	5,454	3,665	0	2,662	373,806	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	32,724	9,807	2,775	20,168	1,143,127	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
91.00	09100	EMERGENCY	279,976	20,938	15,120	82,001	2,999,756	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					0	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	123,626	1,446	0	2,420	594,557	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,517,968	323,031	553,402	770,737	37,173,652	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	31,499	0	0	109,751	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	8,027	0	0	498,193	192.00
194.00	07950	TRANSPORTATION	0	23	0	0	57,106	194.00
194.01	07951	FUND DEVELOPMENT	0	0	0	0	29,632	194.01
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)	2,517,968	362,580	553,402	770,737	37,868,334	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 1/24/2024 11:48 am

		Cost Center Description	OTHER ADMIN & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL	3,958,556					5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	196,343	0	1,878,256			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,053	0	2,281	165,411		8.00
9.00	00900	HOUSEKEEPING	79,188	0	46,719	0	804,244	9.00
10.00	01000	DIETARY	107,263	0	59,927	21	15,390	10.00
11.00	01100	CAFETERIA	8,753	0	55,205	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	124,229	0	16,927	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	67,471	0	27,534	0	674	16.00
17.00	01700	SOCIAL SERVICE	3,752	0	7,026	0	786	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	534,582	0	397,297	97,663	342,052	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	392,431	0	241,717	7,200	3,763	50.00
53.00	05300	ANESTHESIOLOGY	4,625	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	316,988	0	185,896	14,742	60,716	54.00
60.00	06000	LABORATORY	243,692	0	71,607	0	21,062	60.00
64.00	06400	INTRAVENOUS THERAPY	32,144	0	22,196	10,680	72,848	64.00
65.00	06500	RESPIRATORY THERAPY	39,763	0	19,596	189	5,223	65.00
65.01	06501	SLEEP LAB	40,251	0	27,785	41	0	65.01
66.00	06600	PHYSICAL THERAPY	179,510	0	117,573	7,531	29,937	66.00
67.00	06700	OCCUPATIONAL THERAPY	37,926	0	22,196	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	7,110	0	0	0	0	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	338,248	0	38,347	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	118,205	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	391,258	0	26,827	0	7,976	73.00
76.97	07697	CARDIAC REHABILITATION	43,637	0	34,309	0	25,106	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	133,446	0	78,519	3,427	21,175	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
91.00	09100	EMERGENCY	350,186	0	164,201	23,917	89,248	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	69,407	0	56,460	0	11,739	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,877,461	0	1,720,145	165,411	707,695	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	12,812	0	17,771	0	8,537	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	58,158	0	129,550	0	88,012	192.00
194.00	07950	TRANSPORTATION	6,666	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	3,459	0	10,790	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,958,556	0	1,878,256	165,411	804,244	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 1/24/2024 11:48 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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	1,101,434					10.00
11.00	01100	CAFETERIA	516,811	655,748				11.00
13.00	01300	NURSING ADMINISTRATION	0	36,657	1,241,984			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	673,647		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	43,702	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	507,303	169,331	625,061	668,923	43,702	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	76,606	134,313	1,181	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	59,064	23,708	0	0	54.00
60.00	06000	LABORATORY	0	59,310	2,895	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	27,347	6,388	661	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	11,891	0	0	0	65.00
65.01	06501	SLEEP LAB	0	12,432	42,355	1,417	0	65.01
66.00	06600	PHYSICAL THERAPY	0	62,897	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,547	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,194	0	0	0	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	200,831	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	22,161	56,488	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	12,137	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	17,591	0	236	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
91.00	09100	EMERGENCY	49,973	68,449	85,598	1,890	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	13,071	69,345	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,101,434	642,726	1,241,255	673,647	43,702	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	8,010	729	0	0	192.00
194.00	07950	TRANSPORTATION	0	5,012	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,101,434	655,748	1,241,984	673,647	43,702	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 1/24/2024 11:48 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	7,965,271	0	7,965,271		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,218,854	0	4,218,854		50.00
53.00	05300	ANESTHESIOLOGY	0	44,243	0	44,243		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,376,494	0	3,376,494		54.00
60.00	06000	LABORATORY	0	2,486,082	0	2,486,082		60.00
64.00	06400	INTRAVENOUS THERAPY	0	447,618	0	447,618		64.00
65.00	06500	RESPIRATORY THERAPY	0	417,277	0	417,277		65.00
65.01	06501	SLEEP LAB	0	469,079	0	469,079		65.01
66.00	06600	PHYSICAL THERAPY	0	1,935,166	0	1,935,166		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	396,548	0	396,548		67.00
68.00	06800	SPEECH PATHOLOGY	0	71,207	0	71,207		68.00
68.01	03040	AUDIOLOGY	0	0	0	0		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	3,274,090	0	3,274,090		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,331,602	0	1,331,602		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,856,302	0	3,856,302		73.00
76.97	07697	CARDIAC REHABILITATION	0	488,995	0	488,995		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	1,397,521	0	1,397,521		76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	3,833,218	0	3,833,218		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			0			92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	814,579	0	814,579		93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	36,824,146	0	36,824,146		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	148,871	0	148,871		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	782,652	0	782,652		192.00
194.00	07950	TRANSPORTATION	0	68,784	0	68,784		194.00
194.01	07951	FUND DEVELOPMENT	0	43,881	0	43,881		194.01
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	37,868,334	0	37,868,334		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 1/24/2024 11:48 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	38,903	1,622	40,525	40,525	4.00
5.01	01160	COMMUNICATIONS	0	5,576	34,571	40,147	0	5.01
5.02	00550	DATA PROCESSING	460,352	99,044	409,955	969,351	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	179,733	4,478	184,211	412	5.03
5.04	00570	ADMITTING	0	57,071	1,353	58,424	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	13,614	85,199	388	99,201	0	5.05
5.06	00590	OTHER ADMIN & GENERAL	29,479	502,613	29,732	561,824	1,471	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	318,119	60,910	379,029	782	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,319	6,265	0	14,584	0	8.00
9.00	00900	HOUSEKEEPING	0	128,300	1,484	129,784	1,123	9.00
10.00	01000	DIETARY	0	164,572	4,915	169,487	1,011	10.00
11.00	01100	CAFETERIA	0	151,605	0	151,605	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	46,484	99,810	146,294	2,608	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	75,614	641	76,255	0	16.00
17.00	01700	SOCIAL SERVICE	0	19,295	0	19,295	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,091,054	89,396	1,180,450	8,248	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	663,802	860,427	1,524,229	4,170	50.00
53.00	05300	ANESTHESIOLOGY	0	0	1,308	1,308	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	510,506	46,915	557,421	3,217	54.00
60.00	06000	LABORATORY	0	196,647	37,525	234,172	2,691	60.00
64.00	06400	INTRAVENOUS THERAPY	0	60,955	3,473	64,428	393	64.00
65.00	06500	RESPIRATORY THERAPY	0	53,813	21,361	75,174	488	65.00
65.01	06501	SLEEP LAB	0	76,303	16,063	92,366	565	65.01
66.00	06600	PHYSICAL THERAPY	0	322,880	16,048	338,928	3,188	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	60,955	1,418	62,373	647	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	465	465	161	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	105,309	6,078	111,387	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	73,672	2,396	76,068	1,931	73.00
76.97	07697	CARDIAC REHABILITATION	0	94,220	11,570	105,790	728	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	215,629	4,258	219,887	946	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
91.00	09100	EMERGENCY	0	450,929	90,872	541,801	4,640	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0		92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	155,050	41,182	196,232	730	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	511,764	6,010,117	1,900,614	8,422,495	40,150	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	48,802	4,016	52,818	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	355,769	9,104	364,873	261	192.00
194.00	07950	TRANSPORTATION	0	0	2,504	2,504	114	194.00
194.01	07951	FUND DEVELOPMENT	0	29,632	0	29,632	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	511,764	6,444,320	1,916,238	8,872,322	40,525	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 1/24/2024 11:48 am

		Cost Center Description	COMMUNICATIONS	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
		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	01160	COMMUNICATIONS	40,147					5.01
5.02	00550	DATA PROCESSING	4,564	973,915				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	931	27,424	212,978			5.03
5.04	00570	ADMITTING	1,863	123,761	1,493	185,541		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	466	6,329	0	0	105,996	5.05
5.06	00590	OTHER ADMIN & GENERAL	7,734	108,291	15,838	0	0	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	652	10,548	55,861	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	93	1,406	14,827	0	0	9.00
10.00	01000	DIETARY	186	0	801	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	93	703	69	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,304	16,877	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	93	4,922	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,055	94,930	25,814	42,719	4,617	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,446	37,972	12,350	7,853	7,797	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,541	3,136	2,121	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,770	71,725	3,944	25,077	30,987	54.00
60.00	06000	LABORATORY	2,329	26,018	11,401	38,992	19,633	60.00
64.00	06400	INTRAVENOUS THERAPY	0	20,392	2,316	912	629	64.00
65.00	06500	RESPIRATORY THERAPY	0	6,329	95	17,355	3,508	65.00
65.01	06501	SLEEP LAB	745	0	13,281	0	1,510	65.01
66.00	06600	PHYSICAL THERAPY	1,677	35,159	7,686	7,682	3,403	66.00
67.00	06700	OCCUPATIONAL THERAPY	93	4,219	0	3,552	616	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,406	0	294	126	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	6,984	1,968	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,263	2,087	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	838	204,629	368	22,723	12,254	73.00
76.97	07697	CARDIAC REHABILITATION	931	2,110	2,153	0	366	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	931	12,657	5,761	930	2,772	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
91.00	09100	EMERGENCY	1,863	108,291	12,299	5,069	11,269	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	745	47,817	849	0	333	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,402	973,915	189,747	185,541	105,996	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	18,502	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	745	0	4,715	0	0	192.00
194.00	07950	TRANSPORTATION	0	0	14	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	40,147	973,915	212,978	185,541	105,996	202.00

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		Cost Center Description	OTHER ADMIN & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL	695,158					5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	34,479	0	481,351			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,995	0	585	18,164		8.00
9.00	00900	HOUSEKEEPING	13,906	0	11,973	0	173,112	9.00
10.00	01000	DIETARY	18,836	0	15,358	2	3,313	10.00
11.00	01100	CAFETERIA	1,537	0	14,148	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	21,816	0	4,338	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,848	0	7,056	0	145	16.00
17.00	01700	SOCIAL SERVICE	659	0	1,801	0	169	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	93,883	0	101,817	10,724	73,625	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	68,914	0	61,946	791	810	50.00
53.00	05300	ANESTHESIOLOGY	812	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,665	0	47,641	1,619	13,069	54.00
60.00	06000	LABORATORY	42,794	0	18,351	0	4,534	60.00
64.00	06400	INTRAVENOUS THERAPY	5,645	0	5,688	1,173	15,680	64.00
65.00	06500	RESPIRATORY THERAPY	6,983	0	5,022	21	1,124	65.00
65.01	06501	SLEEP LAB	7,068	0	7,121	5	0	65.01
66.00	06600	PHYSICAL THERAPY	31,523	0	30,131	827	6,444	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,660	0	5,688	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,249	0	0	0	0	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	59,399	0	9,827	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,758	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,708	0	6,875	0	1,717	73.00
76.97	07697	CARDIAC REHABILITATION	7,663	0	8,793	0	5,404	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	23,434	0	20,123	376	4,558	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
91.00	09100	EMERGENCY	61,495	0	42,081	2,626	19,210	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	12,188	0	14,469	0	2,527	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	680,917	0	440,832	18,164	152,329	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	2,250	0	4,554	0	1,838	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	10,213	0	33,200	0	18,945	192.00
194.00	07950	TRANSPORTATION	1,171	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	607	0	2,765	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	695,158	0	481,351	18,164	173,112	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 1/24/2024 11:48 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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	208,994					10.00
11.00	01100	CAFETERIA	98,064	237,591				11.00
13.00	01300	NURSING ADMINISTRATION	0	13,282	189,203			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	113,485		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	26,939	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	96,259	61,351	95,222	112,689	26,939	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	27,756	20,461	199	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,400	3,612	0	0	54.00
60.00	06000	LABORATORY	0	21,489	441	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	5,189	2,314	101	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,309	0	0	0	65.00
65.01	06501	SLEEP LAB	0	4,504	6,452	239	0	65.01
66.00	06600	PHYSICAL THERAPY	0	22,789	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,184	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,157	0	0	0	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	30,594	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,029	8,605	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	4,398	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	6,374	0	40	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
91.00	09100	EMERGENCY	9,482	24,801	13,040	318	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	4,736	10,564	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	208,994	232,873	189,092	113,485	26,939	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	2,902	111	0	0	192.00
194.00	07950	TRANSPORTATION	0	1,816	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	27,763	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	208,994	265,354	189,203	113,485	26,939	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 1/24/2024 11:48 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		2,035,342	0	2,035,342		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		1,778,694	0	1,778,694		50.00
53.00	05300	ANESTHESIOLOGY		9,918	0	9,918		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		837,147	0	837,147		54.00
60.00	06000	LABORATORY		422,845	0	422,845		60.00
64.00	06400	INTRAVENOUS THERAPY		124,860	0	124,860		64.00
65.00	06500	RESPIRATORY THERAPY		120,408	0	120,408		65.00
65.01	06501	SLEEP LAB		133,856	0	133,856		65.01
66.00	06600	PHYSICAL THERAPY		489,437	0	489,437		66.00
67.00	06700	OCCUPATIONAL THERAPY		88,032	0	88,032		67.00
68.00	06800	SPEECH PATHOLOGY		4,858	0	4,858		68.00
68.01	03040	AUDIOLOGY		0	0	0		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT		189,565	0	189,565		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		55,702	0	55,702		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		412,745	0	412,745		73.00
76.97	07697	CARDIAC REHABILITATION		138,336	0	138,336		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		298,789	0	298,789		76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC		0	0	0		90.00
91.00	09100	EMERGENCY		858,285	0	858,285		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			0			92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER		291,190	0	291,190		93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM		0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	8,290,009	0	8,290,009		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN		79,962	0	79,962		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES		435,965	0	435,965		192.00
194.00	07950	TRANSPORTATION		5,619	0	5,619		194.00
194.01	07951	FUND DEVELOPMENT		33,004	0	33,004		194.01
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	27,763	0	27,763		201.00
202.00		TOTAL (sum lines 118 through 201)	0	8,872,322	0	8,872,322		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 1/24/2024 11:48 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (TELEPHONES)	DATA PROCESSING (WORK ORDERS)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	102,868					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,619,791				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	621	1,371	12,134,175			4.00
5.01	01160	COMMUNICATIONS	89	29,223	0	431		5.01
5.02	00550	DATA PROCESSING	1,581	346,534	0	49	1,385	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	2,869	3,785	123,226	10	39	5.03
5.04	00570	ADMITTING	911	1,144	0	20	176	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,360	328	0	5	9	5.05
5.06	00590	OTHER ADMIN & GENERAL	8,023	25,132	440,420	83	154	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	5,078	51,487	234,079	7	15	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	100	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	2,048	1,254	336,303	1	2	9.00
10.00	01000	DIETARY	2,627	4,155	302,687	2	0	10.00
11.00	01100	CAFETERIA	2,420	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	742	84,369	780,828	1	1	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,207	542	0	14	24	16.00
17.00	01700	SOCIAL SERVICE	308	0	0	1	7	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,416	75,566	2,470,521	65	135	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,596	727,316	1,248,609	37	54	50.00
53.00	05300	ANESTHESIOLOGY	0	1,106	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,149	39,657	963,244	19	102	54.00
60.00	06000	LABORATORY	3,139	31,720	805,731	25	37	60.00
64.00	06400	INTRAVENOUS THERAPY	973	2,936	117,583	0	29	64.00
65.00	06500	RESPIRATORY THERAPY	859	18,056	146,177	0	9	65.00
65.01	06501	SLEEP LAB	1,218	13,578	169,202	8	0	65.01
66.00	06600	PHYSICAL THERAPY	5,154	13,565	954,539	18	50	66.00
67.00	06700	OCCUPATIONAL THERAPY	973	1,199	193,782	1	6	67.00
68.00	06800	SPEECH PATHOLOGY	0	393	48,162	0	2	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,681	5,138	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	1,176	2,025	578,227	9	291	73.00
76.97	07697	CARDIAC REHABILITATION	1,504	9,780	217,897	10	3	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	3,442	3,599	283,143	10	18	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
91.00	09100	EMERGENCY	7,198	76,814	1,389,182	20	154	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	2,475	34,811	218,429	8	68	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	95,937	1,606,583	12,021,971	423	1,385	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	779	3,395	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	5,679	7,696	78,089	8	0	192.00
194.00	07950	TRANSPORTATION	0	2,117	34,115	0	0	194.00
194.01	07951	FUND DEVELOPMENT	473	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,444,320	1,916,238	1,657,299	50,240	2,517,968	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	62.646498	1.183016	0.136581	116.566125	1,818.027437	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			40,525	40,147	973,915	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003340	93.148492	703.187726	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: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 1/24/2024 11:48 am

		Cost Center Description	PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
		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	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	216,462					5.03
5.04	00570	ADMITTING	1,517	25,566,660				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	150,243,100			5.05
5.06	00590	OTHER ADMIN & GENERAL	16,097	0	0	-3,958,556	33,909,778	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	56,774	0	0	0	1,681,913	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	146,077	8.00
9.00	00900	HOUSEKEEPING	15,070	0	0	0	678,337	9.00
10.00	01000	DIETARY	814	0	0	0	918,833	10.00
11.00	01100	CAFETERIA	0	0	0	0	74,979	11.00
13.00	01300	NURSING ADMINISTRATION	70	0	0	0	1,064,171	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	577,968	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	32,138	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,236	5,886,084	6,548,331	0	4,579,357	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,552	1,082,135	11,059,639	0	3,361,643	50.00
53.00	05300	ANESTHESIOLOGY	2,583	432,112	3,008,913	0	39,618	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,009	3,455,525	43,847,354	0	2,715,380	54.00
60.00	06000	LABORATORY	11,588	5,372,956	27,848,655	0	2,087,516	60.00
64.00	06400	INTRAVENOUS THERAPY	2,354	125,702	892,073	0	275,354	64.00
65.00	06500	RESPIRATORY THERAPY	97	2,391,541	4,975,776	0	340,615	65.00
65.01	06501	SLEEP LAB	13,498	0	2,142,339	0	344,798	65.01
66.00	06600	PHYSICAL THERAPY	7,812	1,058,565	4,826,798	0	1,537,718	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	489,478	874,235	0	324,879	67.00
68.00	06800	SPEECH PATHOLOGY	0	40,464	179,326	0	60,903	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	962,446	2,791,050	0	2,897,495	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	311,775	2,960,205	0	1,012,566	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	374	3,131,132	17,381,672	0	3,351,592	73.00
76.97	07697	CARDIAC REHABILITATION	2,188	0	518,880	0	373,806	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	5,855	128,199	3,931,448	0	1,143,127	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
91.00	09100	EMERGENCY	12,500	698,546	15,984,691	0	2,999,756	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	863	0	471,715	0	594,557	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	192,851	25,566,660	150,243,100	-3,958,556	33,215,096	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	18,805	0	0	0	109,751	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	4,792	0	0	0	498,193	192.00
194.00	07950	TRANSPORTATION	14	0	0	0	57,106	194.00
194.01	07951	FUND DEVELOPMENT	0	0	0	0	29,632	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	362,580	553,402	770,737		3,958,556	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.675028	0.021645	0.005130		0.116738	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	212,978	185,541	105,996		695,158	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.983905	0.007257	0.000705		0.020500	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: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 1/24/2024 11:48 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS	87,414					6.00
7.00	00700	OPERATION OF PLANT	5,078	82,336				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	100	100	277,489			8.00
9.00	00900	HOUSEKEEPING	2,048	2,048	0	14,319		9.00
10.00	01000	DIETARY	2,627	2,627	35	274	52,479	10.00
11.00	01100	CAFETERIA	2,420	2,420	0	0	24,624	11.00
13.00	01300	NURSING ADMINISTRATION	742	742	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,207	1,207	0	12	0	16.00
17.00	01700	SOCIAL SERVICE	308	308	0	14	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,416	17,416	163,838	6,090	24,171	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,596	10,596	12,079	67	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,149	8,149	24,730	1,081	0	54.00
60.00	06000	LABORATORY	3,139	3,139	0	375	0	60.00
64.00	06400	INTRAVENOUS THERAPY	973	973	17,917	1,297	1,303	64.00
65.00	06500	RESPIRATORY THERAPY	859	859	317	93	0	65.00
65.01	06501	SLEEP LAB	1,218	1,218	69	0	0	65.01
66.00	06600	PHYSICAL THERAPY	5,154	5,154	12,633	533	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	973	973	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,681	1,681	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	1,176	1,176	0	142	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,504	1,504	0	447	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	3,442	3,442	5,749	377	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
91.00	09100	EMERGENCY	7,198	7,198	40,122	1,589	2,381	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	2,475	2,475	0	209	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	80,483	75,405	277,489	12,600	52,479	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	779	779	0	152	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	5,679	5,679	0	1,567	0	192.00
194.00	07950	TRANSPORTATION	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	473	473	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,878,256	165,411	804,244	1,101,434	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	22.812087	0.596099	56.166213	20.988090	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	481,351	18,164	173,112	208,994	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	5.846179	0.065458	12.089671	3.982431	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: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 1/24/2024 11:48 am

		Cost Center Description	CAFETERIA (MEALS FTES)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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	13,345					11.00
13.00	01300	NURSING ADMINISTRATION	746	54,483				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	2,852			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	100		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,446	27,420	2,832	100	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,559	5,892	5	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,202	1,040	0	0	0	54.00
60.00	06000	LABORATORY	1,207	127	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	130	29	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	242	0	0	0	0	65.00
65.01	06501	SLEEP LAB	253	1,858	6	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1,280	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	235	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	65	0	0	0	0	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,810	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	451	2,478	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	247	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	358	0	1	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
91.00	09100	EMERGENCY	1,393	3,755	8	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	266	3,042	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,080	54,451	2,852	100	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	163	32	0	0	0	192.00
194.00	07950	TRANSPORTATION	102	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	655,748	1,241,984	673,647	43,702	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	49.138104	22.795808	236.201613	437.020000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	265,354	189,203	113,485	26,939	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	17.803747	3.472698	39.791374	269.390000	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: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 1/24/2024 11:48 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	7,965,271		7,965,271	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,218,854		4,218,854	0	0	50.00
53.00	05300	ANESTHESIOLOGY	44,243		44,243	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,376,494		3,376,494	0	0	54.00
60.00	06000	LABORATORY	2,486,082		2,486,082	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	447,618		447,618	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	417,277	0	417,277	0	0	65.00
65.01	06501	SLEEP LAB	469,079	0	469,079	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1,935,166	0	1,935,166	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	396,548	0	396,548	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	71,207	0	71,207	0	0	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	3,274,090		3,274,090	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,331,602		1,331,602	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,856,302		3,856,302	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	488,995		488,995	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,397,521		1,397,521	0	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	3,833,218		3,833,218	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	649,491		649,491		0	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	814,579		814,579	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	37,473,637	0	37,473,637	0	0	200.00
201.00		Less Observation Beds	649,491		649,491		0	201.00
202.00		Total (see instructions)	36,824,146	0	36,824,146	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 1/24/2024 11:48 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	5,803,987		5,803,987			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,082,135	9,977,504	11,059,639	0.381464	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	432,112	2,576,801	3,008,913	0.014704	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,455,525	40,391,829	43,847,354	0.077006	0.000000	54.00
60.00	06000	LABORATORY	5,372,956	22,475,699	27,848,655	0.089271	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	125,702	766,371	892,073	0.501773	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,391,541	2,584,235	4,975,776	0.083862	0.000000	65.00
65.01	06501	SLEEP LAB	0	2,142,339	2,142,339	0.218956	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	1,058,565	3,768,233	4,826,798	0.400921	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	489,478	384,757	874,235	0.453594	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	40,464	138,862	179,326	0.397081	0.000000	68.00
68.01	03040	AUDIOLOGY	0	0	0	0.000000	0.000000	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	962,446	1,828,604	2,791,050	1.173067	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	311,775	2,648,430	2,960,205	0.449834	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,131,132	14,250,540	17,381,672	0.221860	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	518,880	518,880	0.942405	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	128,199	3,803,249	3,931,448	0.355472	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	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	698,546	15,286,145	15,984,691	0.239806	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	82,097	662,247	744,344	0.872568	0.000000	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	471,715	471,715	1.726846	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	25,566,660	124,676,440	150,243,100			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	25,566,660	124,676,440	150,243,100			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 1/24/2024 11:48 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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
65.01	06501	SLEEP LAB	0.000000	65.01
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
68.01	03040	AUDIOLOGY	0.000000	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 1/24/2024 11:48 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	7,965,271		7,965,271	0	7,965,271	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,218,854		4,218,854	0	4,218,854	50.00
53.00	05300	ANESTHESIOLOGY	44,243		44,243	0	44,243	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,376,494		3,376,494	0	3,376,494	54.00
60.00	06000	LABORATORY	2,486,082		2,486,082	0	2,486,082	60.00
64.00	06400	INTRAVENOUS THERAPY	447,618		447,618	0	447,618	64.00
65.00	06500	RESPIRATORY THERAPY	417,277	0	417,277	0	417,277	65.00
65.01	06501	SLEEP LAB	469,079	0	469,079	0	469,079	65.01
66.00	06600	PHYSICAL THERAPY	1,935,166	0	1,935,166	0	1,935,166	66.00
67.00	06700	OCCUPATIONAL THERAPY	396,548	0	396,548	0	396,548	67.00
68.00	06800	SPEECH PATHOLOGY	71,207	0	71,207	0	71,207	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	3,274,090		3,274,090	0	3,274,090	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,331,602		1,331,602	0	1,331,602	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,856,302		3,856,302	0	3,856,302	73.00
76.97	07697	CARDIAC REHABILITATION	488,995		488,995	0	488,995	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,397,521		1,397,521	0	1,397,521	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	3,833,218		3,833,218	0	3,833,218	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	649,491		649,491		649,491	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	814,579		814,579	0	814,579	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	37,473,637	0	37,473,637	0	37,473,637	200.00
201.00		Less Observation Beds	649,491		649,491		649,491	201.00
202.00		Total (see instructions)	36,824,146	0	36,824,146	0	36,824,146	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 1/24/2024 11:48 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	5,803,987		5,803,987			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,082,135	9,977,504	11,059,639	0.381464	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	432,112	2,576,801	3,008,913	0.014704	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,455,525	40,391,829	43,847,354	0.077006	0.000000	54.00
60.00	06000	LABORATORY	5,372,956	22,475,699	27,848,655	0.089271	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	125,702	766,371	892,073	0.501773	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,391,541	2,584,235	4,975,776	0.083862	0.000000	65.00
65.01	06501	SLEEP LAB	0	2,142,339	2,142,339	0.218956	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	1,058,565	3,768,233	4,826,798	0.400921	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	489,478	384,757	874,235	0.453594	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	40,464	138,862	179,326	0.397081	0.000000	68.00
68.01	03040	AUDIOLOGY	0	0	0	0.000000	0.000000	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	962,446	1,828,604	2,791,050	1.173067	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	311,775	2,648,430	2,960,205	0.449834	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,131,132	14,250,540	17,381,672	0.221860	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	518,880	518,880	0.942405	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	128,199	3,803,249	3,931,448	0.355472	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	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	698,546	15,286,145	15,984,691	0.239806	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	82,097	662,247	744,344	0.872568	0.000000	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	471,715	471,715	1.726846	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	25,566,660	124,676,440	150,243,100			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	25,566,660	124,676,440	150,243,100			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 1/24/2024 11:48 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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
65.01	06501	SLEEP LAB	0.000000		65.01
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
68.01	03040	AUDIOLOGY	0.000000		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000		92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 1/24/2024 11:48 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	1,778,694	11,059,639	0.160827	355,794	57,221	50.00
53.00	05300	ANESTHESIOLOGY	9,918	3,008,913	0.003296	118,633	391	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	837,147	43,847,354	0.019092	956,372	18,259	54.00
60.00	06000	LABORATORY	422,845	27,848,655	0.015184	1,595,932	24,233	60.00
64.00	06400	INTRAVENOUS THERAPY	124,860	892,073	0.139966	23,744	3,323	64.00
65.00	06500	RESPIRATORY THERAPY	120,408	4,975,776	0.024199	616,786	14,926	65.00
65.01	06501	SLEEP LAB	133,856	2,142,339	0.062481	0	0	65.01
66.00	06600	PHYSICAL THERAPY	489,437	4,826,798	0.101400	204,654	20,752	66.00
67.00	06700	OCCUPATIONAL THERAPY	88,032	874,235	0.100696	71,181	7,168	67.00
68.00	06800	SPEECH PATHOLOGY	4,858	179,326	0.027090	21,950	595	68.00
68.01	03040	AUDIOLOGY	0	0	0.000000	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	189,565	2,791,050	0.067919	260,695	17,706	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	55,702	2,960,205	0.018817	84,600	1,592	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	412,745	17,381,672	0.023746	724,821	17,212	73.00
76.97	07697	CARDIAC REHABILITATION	138,336	518,880	0.266605	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	298,789	3,931,448	0.076000	10,152	772	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	858,285	15,984,691	0.053694	22,512	1,209	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	165,962	744,344	0.222964	6,510	1,451	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	291,190	471,715	0.617301	0	0	93.00
200.00		Total (lines 50 through 199)	6,420,629	144,439,113		5,074,336	186,810	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 1/24/2024 11:48 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
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
68.01	03040	AUDIOLOGY	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0		0		0	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	0	0	0	0	93.00
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: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 1/24/2024 11:48 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	11,059,639	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,008,913	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	43,847,354	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	27,848,655	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	892,073	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,975,776	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	2,142,339	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	4,826,798	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	874,235	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	179,326	0.000000	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	0.000000	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	2,791,050	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,960,205	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	17,381,672	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	518,880	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	3,931,448	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	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	15,984,691	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	744,344	0.000000	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	0	0	471,715	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	144,439,113		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 1/24/2024 11:48 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	355,794	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	118,633	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	956,372	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	1,595,932	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	23,744	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	616,786	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	204,654	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	71,181	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	21,950	0	0	0	68.00
68.01	03040	AUDIOLOGY	0.000000	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	260,695	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	84,600	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	724,821	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	10,152	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	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	22,512	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	6,510	0	0	0	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		5,074,336	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 1/24/2024 11:48 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	0.381464	0	2,358,873	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.014704	0	590,592	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.077006	0	11,168,935	0	0	54.00
60.00	06000	LABORATORY	0.089271	0	5,042,240	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.501773	0	263,310	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.083862	0	726,515	0	0	65.00
65.01	06501	SLEEP LAB	0.218956	0	512,226	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.400921	0	1,232,956	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.453594	0	145,639	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.397081	0	6,623	0	0	68.00
68.01	03040	AUDIOLOGY	0.000000	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.173067	0	438,089	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.449834	0	749,760	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.221860	0	7,140,309	1,109	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.942405	0	211,873	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.355472	0	1,516,635	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	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.239806	0	3,540,492	1,188	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.872568	0	298,068	0	0	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	1.726846	0	306,773	0	0	93.00
200.00		Subtotal (see instructions)		0	36,249,908	2,297	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	36,249,908	2,297	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 1/24/2024 11:48 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	899,825	0		50.00
53.00	05300	ANESTHESIOLOGY	8,684	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	860,075	0		54.00
60.00	06000	LABORATORY	450,126	0		60.00
64.00	06400	INTRAVENOUS THERAPY	132,122	0		64.00
65.00	06500	RESPIRATORY THERAPY	60,927	0		65.00
65.01	06501	SLEEP LAB	112,155	0		65.01
66.00	06600	PHYSICAL THERAPY	494,318	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	66,061	0		67.00
68.00	06800	SPEECH PATHOLOGY	2,630	0		68.00
68.01	03040	AUDIOLOGY	0	0		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	513,908	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	337,268	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,584,149	246		73.00
76.97	07697	CARDIAC REHABILITATION	199,670	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	539,121	0		76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	849,031	285		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	260,085	0		92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	529,750	0		93.00
200.00		Subtotal (see instructions)	7,899,905	531		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,899,905	531		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 1/24/2024 11:48 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)	6,668	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,978	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,451	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,417	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)	1,028	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	142	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)	103	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,458	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)	727	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)	527	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)	7,965,271	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)	28,622	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)	20,761	25.00
26.00	Total swing-bed cost (see instructions)	3,062,674	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,902,597	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)	4,902,597	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)	1,232.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,796,883	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)	1,796,883	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 1/24/2024 11:48 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)						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)	1,059,641	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)	2,856,524	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)	895,977	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	649,491	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	1,545,468	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)	527	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,232.43	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1336	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 1/24/2024 11:48 am
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	649,491	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	2,035,342	7,965,271	0.255527	649,491	165,962	90.00
91.00	Nursing Program cost	0	7,965,271	0.000000	649,491	0	91.00
92.00	Allied health cost	0	7,965,271	0.000000	649,491	0	92.00
93.00	All other Medical Education	0	7,965,271	0.000000	649,491	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 1/24/2024 11:48 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		1,909,621		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.381464	355,794	135,723	50.00
53.00	05300	ANESTHESIOLOGY	0.014704	118,633	1,744	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.077006	956,372	73,646	54.00
60.00	06000	LABORATORY	0.089271	1,595,932	142,470	60.00
64.00	06400	INTRAVENOUS THERAPY	0.501773	23,744	11,914	64.00
65.00	06500	RESPIRATORY THERAPY	0.083862	616,786	51,725	65.00
65.01	06501	SLEEP LAB	0.218956	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.400921	204,654	82,050	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.453594	71,181	32,287	67.00
68.00	06800	SPEECH PATHOLOGY	0.397081	21,950	8,716	68.00
68.01	03040	AUDIOLOGY	0.000000	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.173067	260,695	305,813	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.449834	84,600	38,056	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.221860	724,821	160,809	73.00
76.97	07697	CARDIAC REHABILITATION	0.942405	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.355472	10,152	3,609	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.239806	22,512	5,399	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.872568	6,510	5,680	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	1.726846	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,074,336	1,059,641	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)		5,074,336		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1336 | Component CCN: 14-Z336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 1/24/2024 11:48 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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.381464	4,923	1,878	50.00
53.00	05300	ANESTHESIOLOGY	0.014704	1,008	15	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.077006	169,246	13,033	54.00
60.00	06000	LABORATORY	0.089271	460,421	41,102	60.00
64.00	06400	INTRAVENOUS THERAPY	0.501773	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.083862	417,173	34,985	65.00
65.01	06501	SLEEP LAB	0.218956	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.400921	308,873	123,834	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.453594	171,871	77,960	67.00
68.00	06800	SPEECH PATHOLOGY	0.397081	4,900	1,946	68.00
68.01	03040	AUDIOLOGY	0.000000	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.173067	111,397	130,676	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.449834	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.221860	414,208	91,896	73.00
76.97	07697	CARDIAC REHABILITATION	0.942405	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.355472	18,209	6,473	76.98
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.239806	3,504	840	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.872568	0	0	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	1.726846	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,085,733	524,638	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,085,733		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1336	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 1/24/2024 11:48 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,900,436	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)	7,900,436	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)	7,979,440	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)	70,899	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	6,182,223	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)	1,726,318	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)	1,726,318	30.00
31.00	Primary payer payments	348	31.00
32.00	Subtotal (line 30 minus line 31)	1,725,970	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)	383,144	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	249,044	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	207,037	36.00
37.00	Subtotal (see instructions)	1,975,014	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)	1,975,014	40.00
40.01	Sequestration adjustment (see instructions)	39,500	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	2,185,625	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)	-250,111	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: 14-1336	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 1/24/2024 11:48 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: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 1/24/2024 11:48 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		2,339,743		2,189,415	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	02/27/2023	100,651	06/15/2023	41,709	3.01
3.02		06/15/2023	29,816		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	02/27/2023	45,499	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)		130,467		-3,790	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)		2,470,210		2,185,625	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		32,561		250,111	6.02
7.00	Total Medicare program liability (see instructions)		2,437,649		1,935,514	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: 14-1336 | Component CCN: 14-Z336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 1/24/2024 11:48 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		1,759,635		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	02/27/2023	102,301		0	3.01
3.02		06/15/2023	5,874		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)		108,175		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)		1,867,810		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		152,652		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,020,462		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: 14-1336	Period: From 07/01/2022 To 06/30/2023	Worksheet E-1 Part II Date/Time Prepared: 1/24/2024 11:48 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: 14-1336 | Component CCN: 14-Z336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-2 | Date/Time Prepared: 1/24/2024 11:48 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)	1,560,923	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)	529,884	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	1,254	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)	2,090,807	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,090,807	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)	2,090,807	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	30,122	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	2,060,685	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)	1,556	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	1,011	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	2,061,696	0	19.00
19.01	Sequestration adjustment (see instructions)	41,234	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	1,867,810	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)	152,652	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	Provider CCN: 14-1336	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part V Date/Time Prepared: 1/24/2024 11:48 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,856,524	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)	2,856,524	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,885,089	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)	2,885,089	19.00
20.00	Deductibles (exclude professional component)	430,904	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,454,185	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,454,185	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	51,095	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	33,212	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	37,748	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,487,397	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)	2,487,397	30.00
30.01	Sequestration adjustment (see instructions)	49,748	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2,470,210	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)	-32,561	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: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G | Date/Time Prepared: 1/24/2024 11:48 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	354,333	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	-60,392	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	6,130,910	0	0	0	6.00
7.00	Inventory	742,738	0	0	0	7.00
8.00	Prepaid expenses	332,810	0	0	0	8.00
9.00	Other current assets	7,529,921	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	15,030,320	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,034,874	0	0	0	12.00
13.00	Land improvements	1,484,818	0	0	0	13.00
14.00	Accumulated depreciation	-1,414,606	0	0	0	14.00
15.00	Buildings	17,322,320	0	0	0	15.00
16.00	Accumulated depreciation	-3,879,501	0	0	0	16.00
17.00	Leasehold improvements	139,133	0	0	0	17.00
18.00	Accumulated depreciation	-113,592	0	0	0	18.00
19.00	Fixed equipment	22,865,298	0	0	0	19.00
20.00	Accumulated depreciation	-9,015,056	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	13,668,093	0	0	0	23.00
24.00	Accumulated depreciation	-10,535,828	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)	32,555,953	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	8,163,625	0	0	0	31.00
32.00	Deposits on leases	6,663,720	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	14,827,345	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	62,413,618	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,424,957	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,613,619	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	6,432,934	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,361,891	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,833,401	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	34,627,550	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	34,627,550	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	46,460,951	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	15,952,667				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)	15,952,667	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	62,413,618	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-1 | Date/Time Prepared: 1/24/2024 11:48 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		7,832,132		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,499,460				2.00
3.00	Total (sum of line 1 and line 2)		17,331,592		0		3.00
4.00	NET ASSET RELEASED PPE	2,767		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)		2,767		0		10.00
11.00	Subtotal (line 3 plus line 10)		17,334,359		0		11.00
12.00	AFS TRANSFER TO AFFILIATE	1,381,691		0		0	12.00
13.00	ROUNDING	1		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		1,381,692		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,952,667		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	NET ASSET RELEASED PPE		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	AFS TRANSFER TO AFFILIATE		0		12.00
13.00	ROUNDING		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: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 1/24/2024 11:48 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,605,625		4,605,625	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,116,488		1,116,488	5.00
6.00	Swing bed - NF	111,877		111,877	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)	5,833,990		5,833,990	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)	5,833,990		5,833,990	17.00
18.00	Ancillary services	19,223,021	110,963,128	130,186,149	18.00
19.00	Outpatient services	796,152	16,640,561	17,436,713	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	PRO FEES	40,817	179,428	220,245	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	25,893,980	127,783,117	153,677,097	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		45,210,055		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)		45,210,055		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1336 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-3 | Date/Time Prepared: 1/24/2024 11:48 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	153,677,097	1.00
2.00	Less contractual allowances and discounts on patients' accounts	102,806,763	2.00
3.00	Net patient revenues (line 1 minus line 2)	50,870,334	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	45,210,055	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,660,279	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	85,076	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	135,258	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	4,189	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	22,024	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	174,706	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	225,142	24.00
24.01	GRANTS	139,360	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	785,755	25.00
26.00	Total (line 5 plus line 25)	6,446,034	26.00
27.00	NON OPERATING EXPENSES	-3,587,072	27.00
27.01	NON OPERATING PENSION	533,646	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	-3,053,426	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	9,499,460	29.00