

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: 14-1334	Period: From 04/01/2022 To 03/31/2023	Worksheet S Parts I-III Date/Time Prepared: 8/29/2023 11:32 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 8/29/2023	Time: 11:32 am
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SAINT JOSEPH MEMORIAL HOSPITAL (14-1334) for the cost reporting period beginning 04/01/2022 and ending 03/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	109,205	304,568	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	-218,019	0	0	5.00
6.00	SWING BED - NF	0			0	6.00
200.00	TOTAL	0	-108,814	304,568	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1334		Period: From 04/01/2022 To 03/31/2023		Worksheet S-2 Part I Date/Time Prepared: 8/29/2023 11:22 am				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 2 SOUTH HOSPITAL DRIVE			PO Box:				1.00				
2.00	City: MURPHYSBORO			State: IL		Zip Code: 62966		County: JACKSON				
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
								V	XVIII			
								XIX				
Hospital and Hospital-Based Component Identification:												
3.00	Hospital			SAINT JOSEPH MEMORIAL HOSPITAL	141334	16060	1	05/01/2004	N	0	0	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			SAINT JOSEPH HOSPITAL SWING BED	14Z334	16060		11/14/2013	N	0	0	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)						04/01/2022	03/31/2023		20.00		
21.00	Type of Control (see instructions)						2			21.00		
							1.00	2.00		3.00		
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00		
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01		
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03		
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.									22.04		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00		

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		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	0	25.00	
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR 412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.								58.00

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				V	XVIII	XIX	
				1.00	2.00	3.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.			N			59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.			N			60.00
				Y/N	IME	Direct GME	
				1.00	2.00	3.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)			N		0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
				Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count
				1.00	2.00	3.00	4.00
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.					0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.					0.00	61.20
				1.00			
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						0.00
62.01	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
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: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet S-2
Part I
Date/Time Prepared:
8/29/2023 11:22 am

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1334	Period: From 04/01/2022 To 03/31/2023	Worksheet S-2 Part I Date/Time Prepared: 8/29/2023 11:22 am
		V 1.00	XIX 2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
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	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 1.00	Occupational 2.00	Speech 3.00
			Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N
				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
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		0115.00
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: 14-1334	Period: From 04/01/2022 To 03/31/2023	Worksheet S-2 Part I Date/Time Prepared: 8/29/2023 11:22 am	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	789,114	0	0	118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	Y		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.				123.00
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	14H124		140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: SOUTHERN ILLINOIS HEALTHCARE	Contractor's Name: NGS		Contractor's Number: 06101	
142.00	Street: 1239 E. MAIN STREET	PO Box: 3988			
143.00	City: CARBONDALE	State: IL		Zip Code: 62902-3988	
				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: 14-1334		Period: From 04/01/2022 To 03/31/2023		Worksheet S-2 Part I Date/Time Prepared: 8/29/2023 11:22 am		
						1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N		155.00	
156.00	Subprovider - IPF	N	N	N	N		156.00	
157.00	Subprovider - IRF	N	N	N	N		157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00	
161.00	CMHC		N	N	N		161.00	
						1.00		
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	
						1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
				Beginning	Ending			
				1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00
				1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1334		Period: From 04/01/2022 To 03/31/2023		Worksheet S-2 Part II Date/Time Prepared: 8/29/2023 11:22 am	
				Y/N	Date		
				1.00	2.00		
PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE							
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y					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.			Y			13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N			14.00
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)	Y	07/28/2023	Y	07/28/2023		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet S-2
Part II
Date/Time Prepared:
8/29/2023 11:22 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 relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LUANNE	WARREN		41.00
42.00	Enter the employer/company name of the cost report preparer.	SIH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-457-5200	LUANNE.WARREN@SIH.NET		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet S-2
Part II
Date/Time Prepared:
8/29/2023 11:22 am

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

HFS Supplemental Information

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet S-2
Part IX
Date/Time Prepared:
8/29/2023 11:22 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet S-3
Part I
Date/Time Prepared:
8/29/2023 11:22 am

Component	Worksheet A Line No.	No. of Beds	Bed Days Avai l a b l e	CAH/REH Hours	I /P Days / O/P Vi s i t s / T r i p s		
					Title V		
					1.00		2.00
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	21,426.02	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	21,426.02	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	21,426.02	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: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet S-3
Part I
Date/Time Prepared:
8/29/2023 11:22 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)	413	8	892			1.00
2.00	HMO and other (see instructions)	228	141				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	1,925	0	2,876			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	311			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,338	8	4,079			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)	2,338	8	4,079	0.00	217.10	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)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	217.10	27.00
28.00	Observation Bed Days		5	280			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet S-3
Part I
Date/Time Prepared:
8/29/2023 11:22 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
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	104	2	233	1.00
2.00 HMO and other (see instructions)			53	42		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	104	2	233	14.00
15.00 CAH visits						15.00
15.10 REH hours and visits						15.10
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01
34.00 Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet S-3
Part IV
Date/Time Prepared:
8/29/2023 11:22 am

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1334

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

Worksheet S-10

Date/Time Prepared:
8/29/2023 11:22 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)		0.220410	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		10,943,548	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		2,620,885	5.00
6.00	Medicaid charges		65,503,500	6.00
7.00	Medicaid cost (line 1 times line 6)		14,437,626	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)		873,193	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)		873,193	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)	828,986	969,967	1,798,953
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	182,717	969,967	1,152,684
22.00	Payments received from patients for amounts previously written off as charity care	457	0	457
23.00	Cost of charity care (line 21 minus line 22)	182,260	969,967	1,152,227
				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)		4,108,710	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,284,184	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,975,667	27.01
28.00	Non-Medicare bad debt expense (see instructions)		2,133,043	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,161,627	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,313,854	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,187,047	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1334

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

Worksheet A

Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	1,520,614	1,520,614	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	1,449,652	1,449,652	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	93,546	52,557	146,103	5,236,602	4.00
5.01	00550	DATA PROCESSING	0	0	0	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	46,006	30,276	76,282	-23,049	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	525,135	178,178	703,313	-164,280	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	1,000,469	6,975,384	7,975,853	-3,133,065	5.04
6.00	00600	MAINTENANCE & REPAIRS	276,652	1,141,596	1,418,248	-131,067	6.00
7.00	00700	OPERATION OF PLANT	192,816	43,884	236,700	-30,595	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	266,224	266,224	0	8.00
9.00	00900	HOUSEKEEPING	341,428	240,048	581,476	-118,208	9.00
10.00	01000	DIETARY	374,720	365,399	740,119	-556,678	10.00
11.00	01100	CAFETERIA	0	0	0	407,479	11.00
13.00	01300	NURSING ADMINISTRATION	1,150,769	411,578	1,562,347	-399,637	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	37,735	15,239	52,974	-15,205	14.00
15.00	01500	PHARMACY	566,199	11,514,281	12,080,480	-157,114	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,163	15,050	47,213	-15,021	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	1,024,342	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,879,849	2,592,922	4,472,771	-478,095	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,622,395	6,238,407	8,860,802	-4,384,993	50.00
51.00	05100	RECOVERY ROOM	167,495	51,732	219,227	-35,372	51.00
53.00	05300	ANESTHESIOLOGY	0	1,280,898	1,280,898	-1,048,525	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,174,828	1,478,282	2,653,110	-820,682	54.00
60.00	06000	LABORATORY	782,315	2,516,165	3,298,480	-307,063	60.00
64.00	06400	INTRAVENOUS THERAPY	750,992	334,015	1,085,007	-180,981	64.00
65.00	06500	RESPIRATORY THERAPY	525,667	466,054	991,721	-221,566	65.00
65.01	03610	SLEEP LAB	580,573	417,525	998,098	-194,227	65.01
65.02	03620	GERIATRIC PSYCH	231,971	127,619	359,590	-45,149	65.02
66.00	06600	PHYSICAL THERAPY	1,256,315	366,972	1,623,287	-262,159	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	964,927	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,387,983	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	150,644	73.00
76.97	07697	CARDIAC REHABILITATION	277,313	86,071	363,384	-72,025	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	195,596	90,983	286,579	-60,437	90.00
91.00	09100	EMERGENCY	1,241,534	3,218,211	4,459,745	-287,050	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,324,481	40,515,550	56,840,031	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	55,495	55,495	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	16,324,481	40,571,045	56,895,526	0	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet A
Date/Time Prepared:
8/29/2023 11:22 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	118,281	1,638,895	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	960,409	2,410,061	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,256,223	4,126,482	4.00
5.01	00550	DATA PROCESSING	3,579,344	3,579,344	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-4,319	48,914	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	740,325	1,279,358	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	295,357	5,138,145	5.04
6.00	00600	MAINTENANCE & REPAIRS	-24,571	1,262,610	6.00
7.00	00700	OPERATION OF PLANT	0	206,105	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	266,224	8.00
9.00	00900	HOUSEKEEPING	0	463,268	9.00
10.00	01000	DIETARY	0	183,441	10.00
11.00	01100	CAFETERIA	-150,844	256,635	11.00
13.00	01300	NURSING ADMINISTRATION	-3,548	1,159,162	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	37,769	14.00
15.00	01500	PHARMACY	-18,004	11,905,362	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-9,139	23,053	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-1,024,342	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-682,365	3,312,311	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	4,475,809	50.00
51.00	05100	RECOVERY ROOM	0	183,855	51.00
53.00	05300	ANESTHESIOLOGY	0	232,373	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-36,220	1,796,208	54.00
60.00	06000	LABORATORY	-188,747	2,802,670	60.00
64.00	06400	INTRAVENOUS THERAPY	0	904,026	64.00
65.00	06500	RESPIRATORY THERAPY	0	770,155	65.00
65.01	03610	SLEEP LAB	-9,622	794,249	65.01
65.02	03620	GERIATRIC PSYCH	0	314,441	65.02
66.00	06600	PHYSICAL THERAPY	-1,303	1,359,825	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	964,927	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,387,983	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	150,644	73.00
76.97	07697	CARDIAC REHABILITATION	0	291,359	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	226,142	90.00
91.00	09100	EMERGENCY	-2,042,014	2,130,681	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	242,455	57,082,486	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-8,728	46,767	192.00
192.01	19201	UNUSED SPACE	0	0	192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	233,727	57,129,253	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet Non-CMS W
Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1. 00	2. 00	
GENERAL SERVICE COST CENTERS				
1. 00	CAP REL COSTS-BLDG & FIXT	00100		1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	00200		2. 00
4. 00	EMPLOYEE BENEFITS DEPARTMENT	00400		4. 00
5. 01	DATA PROCESSING	00550	DATA PROCESSING	5. 01
5. 02	PURCHASING RECEIVING AND STORES	00560	PURCHASING RECEIVING AND STORES	5. 02
5. 03	CASHIERING/ACCOUNTS RECEIVABLE	00580	CASHIERING/ACCOUNTS RECEIVABLE	5. 03
5. 04	OTHER ADMINISTRATIVE AND GENERAL	00590		5. 04
6. 00	MAINTENANCE & REPAIRS	00600		6. 00
7. 00	OPERATION OF PLANT	00700		7. 00
8. 00	LAUNDRY & LINEN SERVICE	00800		8. 00
9. 00	HOUSEKEEPING	00900		9. 00
10. 00	DIETARY	01000		10. 00
11. 00	CAFETERIA	01100		11. 00
13. 00	NURSING ADMINISTRATION	01300		13. 00
14. 00	CENTRAL SERVICES & SUPPLY	01400		14. 00
15. 00	PHARMACY	01500		15. 00
16. 00	MEDICAL RECORDS & LIBRARY	01600		16. 00
19. 00	NONPHYSICIAN ANESTHETISTS	01900		19. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	ADULTS & PEDIATRICS	03000		30. 00
ANCILLARY SERVICE COST CENTERS				
50. 00	OPERATING ROOM	05000		50. 00
51. 00	RECOVERY ROOM	05100		51. 00
53. 00	ANESTHESIOLOGY	05300		53. 00
54. 00	RADIOLOGY-DIAGNOSTIC	05400		54. 00
60. 00	LABORATORY	06000		60. 00
64. 00	INTRAVENOUS THERAPY	06400		64. 00
65. 00	RESPIRATORY THERAPY	06500		65. 00
65. 01	SLEEP LAB	03610	SLEEP LAB	65. 01
65. 02	GERIATRIC PSYCH	03620	STRESS TEST	65. 02
66. 00	PHYSICAL THERAPY	06600		66. 00
71. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71. 00
72. 00	IMPL. DEV. CHARGED TO PATIENTS	07200		72. 00
73. 00	DRUGS CHARGED TO PATIENTS	07300		73. 00
76. 97	CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76. 97
77. 00	ALLOGENEIC HSCT ACQUISITION	07700		77. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00	CLINIC	09000		90. 00
91. 00	EMERGENCY	09100		91. 00
92. 00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92. 00
OTHER REIMBURSABLE COST CENTERS				
102. 00	OPIOID TREATMENT PROGRAM	10200		102. 00
SPECIAL PURPOSE COST CENTERS				
113. 00	INTEREST EXPENSE	11300		113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)			118. 00
NONREIMBURSABLE COST CENTERS				
190. 00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190. 00
192. 00	PHYSICIANS' PRIVATE OFFICES	19200		192. 00
192. 01	UNUSED SPACE	19201		192. 01
200. 00	TOTAL (SUM OF LINES 118 through 199)			200. 00

RECLASSIFICATIONS

Provider CCN: 14-1334

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

Worksheet A-6

Date/Time Prepared:
8/29/2023 11:22 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - Dietary						
1.00	CAFETERIA	11.00	253,834	259,265		1.00
	TOTALS		253,834	259,265		
B - Recl Medical Supplies						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		964,927		1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00			0	964,927		10.00
C - Drugs Charged to Patients						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	63,733		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
	TOTALS		0	63,733		
D - Interest						
1.00	CAP REL COSTS-BLDG & FIXT	1.00		86,095		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00		42,216		2.00
3.00			0	128,311		3.00
E - Implantable Devices						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		2,387,983		1.00
2.00						2.00
3.00			0	2,387,983		3.00
F - Contrast Expense						
1.00	DRUGS CHARGED TO PATIENTS	73.00		86,911		1.00
2.00						2.00
3.00						3.00
4.00			0	86,911		4.00
G - CRNA Reclass						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	1,024,342		1.00
	TOTALS		0	1,024,342		
H - Recl Depreciation						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,434,519		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,407,436		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00

RECLASSIFICATIONS

Provider CCN: 14-1334

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

Worksheet A-6

Date/Time Prepared:
8/29/2023 11:22 am

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
25.00	0.00	0	0		25.00
26.00	0.00	0	0		26.00
27.00	0.00	0	0		27.00
TOTALS		0	2,841,955		
I - Employee Benefits					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		5,236,602	1.00
2.00					2.00
3.00					3.00
4.00					4.00
5.00					5.00
6.00					6.00
7.00					7.00
8.00					8.00
9.00					9.00
10.00					10.00
11.00					11.00
12.00					12.00
13.00					13.00
14.00					14.00
15.00					15.00
16.00					16.00
17.00					17.00
18.00					18.00
19.00					19.00
20.00					20.00
21.00					21.00
22.00					22.00
23.00					23.00
24.00					24.00
25.00					25.00
			0	5,236,602	
500.00	Grand Total: Increases		253,834	12,994,029	500.00

RECLASSIFICATIONS

Provider CCN: 14-1334

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

Worksheet A-6

Date/Time Prepared:
8/29/2023 11:22 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - Dietary						
1.00	DIETARY	10.00	253,834	259,265	0		1.00
	TOTALS		253,834	259,265			
	B - Recl Medical Supplies						
1.00	OTHER ADMINI STRATIVE AND GENERAL	5.04		119			1.00
2.00	ADULTS & PEDI ATRICS	30.00		4,584			2.00
3.00	OPERATING ROOM	50.00		898,265			3.00
4.00	RECOVERY ROOM	51.00		235			4.00
5.00	ANESTHESI OLOGY	53.00		7,496			5.00
6.00	LABORATORY	60.00		3,998			6.00
7.00	INTRAVENOUS THERAPY	64.00		2,670			7.00
8.00	RESPI RATORY THERAPY	65.00		38,563			8.00
9.00	CLINI C	90.00		47			9.00
10.00	EMERGENCY	91.00		8,950			10.00
			0	964,927			
	C - Drugs Charged to Patients						
1.00	OTHER ADMINI STRATIVE AND GENERAL	5.04	0	65	0		1.00
2.00	DI ETARY	10.00	0	436	0		2.00
3.00	CAFETERI A	11.00	0	1,116	0		3.00
4.00	PHARMACY	15.00	0	9,655	0		4.00
5.00	ADULTS & PEDI ATRICS	30.00	0	14,184	0		5.00
6.00	OPERATING ROOM	50.00	0	16,778	0		6.00
7.00	RECOVERY ROOM	51.00	0	584	0		7.00
8.00	ANESTHESI OLOGY	53.00	0	2,491	0		8.00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1,310	0		9.00
10.00	I NTRAVENOUS THERAPY	64.00	0	6,148	0		10.00
11.00	EMERGENCY	91.00	0	10,966	0		11.00
	TOTALS		0	63,733			
	D - Interest						
1.00					11		1.00
2.00					11		2.00
3.00	OTHER ADMINI STRATIVE AND GENERAL	5.04		128,311			3.00
			0	128,311			
	E - Implantable Devices						
1.00	ADULTS & PEDI ATRICS	30.00		50			1.00
2.00	OPERATING ROOM	50.00		2,387,837			2.00
3.00	RADI OLOGY-DI AGNOSTI C	54.00		96			3.00
			0	2,387,983			
	F - Contrast Expense						
1.00	PHARMACY	15.00		2,226			1.00
2.00	OPERATING ROOM	50.00		27,015			2.00
3.00	RADI OLOGY-DI AGNOSTI C	54.00		51,014			3.00
4.00	RESPI RATORY THERAPY	65.00		6,656			4.00
			0	86,911			
	G - CRNA Recl ass						
1.00	ANESTHESI OLOGY	53.00	0	1,024,342	0		1.00
	TOTALS		0	1,024,342			
	H - Recl Depreci ation						
1.00		0.00	0	0	9		1.00
2.00		0.00	0	0	9		2.00
3.00	PURCHASI NG RECEI VI NG AND STORES	5.02	0	7,947	0		3.00
4.00	OTHER ADMINI STRATIVE AND GENERAL	5.04	0	1,368,555	0		4.00
5.00	MAI NTENANCE & REPAI RS	6.00	0	39,860	0		5.00
6.00	OPERATION OF PLANT	7.00	0	1,086	0		6.00
7.00	HOUSEKEEPI NG	9.00	0	4,488	0		7.00
8.00	DI ETARY	10.00	0	6,095	0		8.00
9.00	CAFETERI A	11.00	0	15,588	0		9.00
10.00	NURSI NG ADMINI STRATION	13.00	0	105,875	0		10.00
11.00	CENTRAL SERVI CES & SUPPLY	14.00	0	746	0		11.00
12.00	PHARMACY	15.00	0	29,233	0		12.00
13.00	MEDI CAL RECORDS & LI BRARY	16.00	0	1,106	0		13.00
14.00	ADULTS & PEDI ATRICS	30.00	0	90,723	0		14.00
15.00	OPERATING ROOM	50.00	0	391,889	0		15.00
16.00	RECOVERY ROOM	51.00	0	64	0		16.00
17.00	ANESTHESI OLOGY	53.00	0	14,196	0		17.00
18.00	RADI OLOGY-DI AGNOSTI C	54.00	0	485,760	0		18.00
19.00	LABORATORY	60.00	0	114,862	0		19.00
20.00	I NTRAVENOUS THERAPY	64.00	0	13,291	0		20.00
21.00	RESPI RATORY THERAPY	65.00	0	22,514	0		21.00

RECLASSIFICATIONS

Provider CCN: 14-1334

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

Worksheet A-6

Date/Time Prepared:
8/29/2023 11:22 am

		Decreases					07/27/2025 11:22 AM	
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
22.00	SLEEP LAB	65.01	0	44,577	0		22.00	
23.00	GERIATRIC PSYCH	65.02	0	2,095	0		23.00	
24.00	PHYSICAL THERAPY	66.00	0	8,555	0		24.00	
25.00	CARDIAC REHABILITATION	76.97	0	22,735	0		25.00	
26.00	CLINIC	90.00	0	10,768	0		26.00	
27.00	EMERGENCY	91.00	0	39,347	0		27.00	
	TOTALS		0	2,841,955				
I - Employee Benefits								
1.00	PURCHASING RECEIVING AND STORES	5.02		15,102			1.00	
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.03		164,280			2.00	
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.04		1,636,015			3.00	
4.00	MAINTENANCE & REPAIRS	6.00		91,207			4.00	
5.00	OPERATION OF PLANT	7.00		29,509			5.00	
6.00	HOUSEKEEPING	9.00		113,720			6.00	
7.00	DIETARY	10.00		37,048			7.00	
8.00	CAFETERIA	11.00		88,916			8.00	
9.00	NURSING ADMINISTRATION	13.00		293,762			9.00	
10.00	CENTRAL SERVICES & SUPPLY	14.00		14,459			10.00	
11.00	PHARMACY	15.00		116,000			11.00	
12.00	MEDICAL RECORDS & LIBRARY	16.00		13,915			12.00	
13.00	ADULTS & PEDIATRICS	30.00		368,554			13.00	
14.00	OPERATING ROOM	50.00		663,209			14.00	
15.00	RECOVERY ROOM	51.00		34,489			15.00	
16.00	RADIOLOGY-DIAGNOSTIC	54.00		282,502			16.00	
17.00	LABORATORY	60.00		188,203			17.00	
18.00	INTRAVENOUS THERAPY	64.00		158,872			18.00	
19.00	RESPIRATORY THERAPY	65.00		153,833			19.00	
20.00	SLEEP LAB	65.01		149,650			20.00	
21.00	GERIATRIC PSYCH	65.02		43,054			21.00	
22.00	PHYSICAL THERAPY	66.00		253,604			22.00	
23.00	CARDIAC REHABILITATION	76.97		49,290			23.00	
24.00	CLINIC	90.00		49,622			24.00	
25.00	EMERGENCY	91.00		227,787			25.00	
			0	5,236,602				
500.00	Grand Total: Decreases		253,834	12,994,029			500.00	

RECLASSIFICATIONS

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
8/29/2023 11:22 am

Increases					Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
A - Dietary									
1.00	CAFETERIA	11.00	253,834	259,265	DIETARY	10.00	253,834	259,265	1.00
	TOTALS		253,834	259,265	TOTALS		253,834	259,265	
B - Recl Medical Supplies									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		964,927	OTHER ADMINISTRATIVE AND GENERAL	5.04		119	1.00
2.00					ADULTS & PEDIATRICS	30.00		4,584	2.00
3.00					OPERATING ROOM	50.00		898,265	3.00
4.00					RECOVERY ROOM	51.00		235	4.00
5.00					ANESTHESIOLOGY	53.00		7,496	5.00
6.00					LABORATORY	60.00		3,998	6.00
7.00					INTRAVENOUS THERAPY	64.00		2,670	7.00
8.00					RESPIRATORY THERAPY	65.00		38,563	8.00
9.00					CLINIC	90.00		47	9.00
10.00					EMERGENCY	91.00		8,950	10.00
			0	964,927			0	964,927	
C - Drugs Charged to Patients									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	63,733	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	65	1.00
2.00		0.00	0	0	DIETARY	10.00	0	436	2.00
3.00		0.00	0	0	CAFETERIA	11.00	0	1,116	3.00
4.00		0.00	0	0	PHARMACY	15.00	0	9,655	4.00
5.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	14,184	5.00
6.00		0.00	0	0	OPERATING ROOM	50.00	0	16,778	6.00
7.00		0.00	0	0	RECOVERY ROOM	51.00	0	584	7.00
8.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	2,491	8.00
9.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	1,310	9.00
10.00		0.00	0	0	INTRAVENOUS THERAPY	64.00	0	6,148	10.00
11.00		0.00	0	0	EMERGENCY	91.00	0	10,966	11.00
	TOTALS		0	63,733	TOTALS		0	63,733	
D - Interest									
1.00	CAP REL COSTS-BLDG & FIXT	1.00		86,095					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00		42,216					2.00
3.00					OTHER ADMINISTRATIVE AND GENERAL	5.04		128,311	3.00
			0	128,311			0	128,311	
E - Implantable Devices									
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		2,387,983	ADULTS & PEDIATRICS	30.00		50	1.00
2.00					OPERATING ROOM	50.00		2,387,837	2.00
3.00					RADIOLOGY-DIAGNOSTIC	54.00		96	3.00
			0	2,387,983			0	2,387,983	
F - Contrast Expense									
1.00	DRUGS CHARGED TO PATIENTS	73.00		86,911	PHARMACY	15.00		2,226	1.00
2.00					OPERATING ROOM	50.00		27,015	2.00
3.00					RADIOLOGY-DIAGNOSTIC	54.00		51,014	3.00
4.00					RESPIRATORY THERAPY	65.00		6,656	4.00
			0	86,911			0	86,911	
G - CRNA Reclass									
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	1,024,342	ANESTHESIOLOGY	53.00	0	1,024,342	1.00
	TOTALS		0	1,024,342	TOTALS		0	1,024,342	
H - Recl Depreciation									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,434,519		0.00	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,407,436		0.00	0	0	2.00
3.00		0.00	0	0	PURCHASING RECEIVING AND STORES	5.02	0	7,947	3.00
4.00		0.00	0	0	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	1,368,555	4.00
5.00		0.00	0	0	MAINTENANCE & REPAIRS	6.00	0	39,860	5.00
6.00		0.00	0	0	OPERATION OF PLANT	7.00	0	1,086	6.00
7.00		0.00	0	0	HOUSEKEEPING	9.00	0	4,488	7.00
8.00		0.00	0	0	DIETARY	10.00	0	6,095	8.00
9.00		0.00	0	0	CAFETERIA	11.00	0	15,588	9.00
10.00		0.00	0	0	NURSING	13.00	0	105,875	10.00
11.00		0.00	0	0	ADMINISTRATION				
12.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	746	11.00
					PHARMACY	15.00	0	29,233	12.00

RECLASSIFICATIONS

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
8/29/2023 11:22 am

Increases					Decreases				
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
13.00	0.00	0	0	0	MEDICAL RECORDS & LIBRARY	16.00	0	1,106	13.00
14.00	0.00	0	0	0	ADULTS & PEDIATRICS	30.00	0	90,723	14.00
15.00	0.00	0	0	0	OPERATING ROOM	50.00	0	391,889	15.00
16.00	0.00	0	0	0	RECOVERY ROOM	51.00	0	64	16.00
17.00	0.00	0	0	0	ANESTHESIOLOGY	53.00	0	14,196	17.00
18.00	0.00	0	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	485,760	18.00
19.00	0.00	0	0	0	LABORATORY	60.00	0	114,862	19.00
20.00	0.00	0	0	0	INTRAVENOUS THERAPY	64.00	0	13,291	20.00
21.00	0.00	0	0	0	RESPIRATORY THERAPY	65.00	0	22,514	21.00
22.00	0.00	0	0	0	SLEEP LAB	65.01	0	44,577	22.00
23.00	0.00	0	0	0	GERIATRIC PSYCH	65.02	0	2,095	23.00
24.00	0.00	0	0	0	PHYSICAL THERAPY	66.00	0	8,555	24.00
25.00	0.00	0	0	0	CARDIAC REHABILITATION	76.97	0	22,735	25.00
26.00	0.00	0	0	0	CLINIC	90.00	0	10,768	26.00
27.00	0.00	0	0	0	EMERGENCY	91.00	0	39,347	27.00
TOTALS				2,841,955	TOTALS			2,841,955	
I - Employee Benefits									
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		5,236,602	PURCHASING RECEIVING AND STORES	5.02		15,102	1.00
2.00					CASHIERING/ACCOUNTS RECEIVABLE	5.03		164,280	2.00
3.00					OTHER ADMINISTRATIVE AND GENERAL	5.04		1,636,015	3.00
4.00					MAINTENANCE & REPAIRS	6.00		91,207	4.00
5.00					OPERATION OF PLANT	7.00		29,509	5.00
6.00					HOUSEKEEPING	9.00		113,720	6.00
7.00					DINARY	10.00		37,048	7.00
8.00					CAFETERIA	11.00		88,916	8.00
9.00					NURSING	13.00		293,762	9.00
10.00					ADMINISTRATION				
11.00					CENTRAL SERVICES & SUPPLY	14.00		14,459	10.00
12.00					PHARMACY	15.00		116,000	11.00
13.00					MEDICAL RECORDS & LIBRARY	16.00		13,915	12.00
14.00					ADULTS & PEDIATRICS	30.00		368,554	13.00
15.00					OPERATING ROOM	50.00		663,209	14.00
16.00					RECOVERY ROOM	51.00		34,489	15.00
17.00					RADIOLOGY-DIAGNOSTIC	54.00		282,502	16.00
18.00					LABORATORY	60.00		188,203	17.00
19.00					INTRAVENOUS THERAPY	64.00		158,872	18.00
20.00					RESPIRATORY THERAPY	65.00		153,833	19.00
21.00					SLEEP LAB	65.01		149,650	20.00
22.00					GERIATRIC PSYCH	65.02		43,054	21.00
23.00					PHYSICAL THERAPY	66.00		253,604	22.00
24.00					CARDIAC REHABILITATION	76.97		49,290	23.00
25.00					CLINIC	90.00		49,622	24.00
					EMERGENCY	91.00		227,787	25.00
500.00	Grand Total : Increases		253,834	12,994,029	Grand Total : Decreases		253,834	12,994,029	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet A-7
Part I
Date/Time Prepared:
8/29/2023 11:22 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	179,386	0	0	0	0	1.00
2.00	Land Improvements	1,227,353	1,687	0	1,687	17,958	2.00
3.00	Buildings and Fixtures	20,831,434	2,567,599	0	2,567,599	2,656,008	3.00
4.00	Building Improvements	13,663,219	1,736,089	0	1,736,089	55,774	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	17,865,657	820,274	0	820,274	620,979	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	53,767,049	5,125,649	0	5,125,649	3,350,719	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	53,767,049	5,125,649	0	5,125,649	3,350,719	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	179,386	0				1.00
2.00	Land Improvements	1,211,082	0				2.00
3.00	Buildings and Fixtures	20,743,025	0				3.00
4.00	Building Improvements	15,343,534	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	18,064,952	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	55,541,979	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	55,541,979	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet A-7
Part II
Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet A-7
Part III
Date/Time Prepared:
8/29/2023 11:22 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	37,477,028	0	37,477,028	0.674751	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	18,064,952	0	18,064,952	0.325249	0	2.00
3.00	Total (sum of lines 1-2)	55,541,980	0	55,541,980	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital -Related Costs	Total (sum of col.s. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,552,800	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,367,845	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,920,645	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital -Related Costs (see instructions)	Total (2) (sum of col.s. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	86,095	0	0	0	1,638,895	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	42,216	0	0	0	2,410,061	2.00
3.00	Total (sum of lines 1-2)	128,311	0	0	0	4,048,956	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1334

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

Worksheet A-8

Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,902,833			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	10,057,257			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-150,844	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	-9,139	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-1,024,342	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1334

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

Worksheet A-8

Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.00	EMPLOYEE OUTPATIENT INS PAYMENTS	B	-2,829,218	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	LEASEHOLD REVENUE	B	-5,238	CAP REL COSTS-BLDG & FIXT	1.00	9	33.01
33.02	PURCHASE DISCOUNTS	B	-4,319	PURCHASING RECEIVING AND STORES	5.02	0	33.02
33.03	INTEREST INCOME	B	-62,115	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.03
33.04	BOND REVENUE	B	-32	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.04
33.05	NONALLOWABLE INTEREST EXPENSE	A	-361,328	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.05
33.06	MISCELLANEOUS INCOME	B	-119	SLEEP LAB	65.01	0	33.06
33.08	CONTRACT PHARMACY	B	-18,004	PHARMACY	15.00	0	33.08
34.00	Lobbying Expense	A	-18,921	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	34.00
35.00	Shawnee Building Depreciation	A	-657	CAP REL COSTS-BLDG & FIXT	1.00	9	35.00
35.01	Shawnee Property Insurance	A	-661	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	35.01
36.00	Medicaid Provider Tax	A	-2,391,655	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	36.00
37.00	Real Estate Taxes	A	-7,586	SLEEP LAB	65.01	0	37.00
37.01	Real Estate Taxes	A	-8,728	PHYSICIANS' PRIVATE OFFICES	192.00	0	37.01
38.00	Cable TV	A	-24,571	MAINTENANCE & REPAIRS	6.00	0	38.00
38.01	Cable TV	A	-1,917	SLEEP LAB	65.01	0	38.01
38.02	Cable TV	A	-1,303	PHYSICAL THERAPY	66.00	0	38.02
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		233,727				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: 14-1334

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

Worksheet A-8-1

Date/Time Prepared:
8/29/2023 11:22 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE EXPENSE	124,176	0 1.00
2.00		2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE EXPENSE	960,409	0 2.00
3.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE EXPENSE	1,572,995	0 3.00
4.00		5.01	DATA PROCESSING	HOME OFFICE EXPENSE	3,579,344	0 4.00
4.01		5.03	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE EXPENSE	740,325	0 4.01
4.02		5.04	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE EXPENSE	3,130,069	0 4.02
4.03		54.00	RADIOLOGY-DIAGNOSTIC	RENT	54,176	90,396 4.03
4.04		60.00	LABORATORY	RENT	20,695	34,536 4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				10,182,189	124,932 5.00

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

	Symbol (1)	Name	Percentage of Ownership	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	SIHS	100.00	RELATED ORG	100.00	6.00
7.00	B	SIHE	100.00	RELATED ORG	100.00	7.00
8.00	B	HSSI	100.00	RELATED ORG	100.00	8.00
9.00	B	SIMS	100.00	RELATED ORG	100.00	9.00
10.00	B	SIH CAYMAN	100.00	RELATED ORG	100.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-1334

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

Worksheet A-8-1

Date/Time Prepared:
8/29/2023 11:22 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	124,176	9		1.00
2.00	960,409	9		2.00
3.00	1,572,995	0		3.00
4.00	3,579,344	0		4.00
4.01	740,325	0		4.01
4.02	3,130,069	0		4.02
4.03	-36,220	0		4.03
4.04	-13,841	0		4.04
5.00	10,057,257			5.00

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

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

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

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

6.00	HEALTHCARE		6.00
7.00	HEALTHCARE		7.00
8.00	HEALTHCARE		8.00
9.00	HEALTHCARE		9.00
10.00	CAPTIVE		10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1334

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

Worksheet A-8-2

Date/Time Prepared:
8/29/2023 11:22 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	91.00	EMERGENCY	2,042,014	2,042,014	0	0	0	1.00
2.00	60.00	LABORATORY	174,906	174,906	0	0	0	2.00
3.00	76.97	CARDIAC REHABILITATION	3,650	0	3,650	0	0	3.00
4.00	65.01	SLEEP LAB	36,000	0	36,000	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	682,365	682,365	0	0	0	5.00
6.00	13.00	NURSING ADMINISTRATION	3,548	3,548	0	0	0	6.00
7.00	50.00	OPERATING ROOM	18,304	0	18,304	0	0	7.00
8.00	90.00	CLINIC	2,578	0	2,578	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	2,737	0	2,737	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,966,102	2,902,833	63,269		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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	3.00
4.00	65.01	SLEEP LAB	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	6.00
7.00	50.00	OPERATING ROOM	0	0	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	2,042,014		1.00
2.00	60.00	LABORATORY	0	0	0	174,906		2.00
3.00	76.97	CARDIAC REHABILITATION	0	0	0	0		3.00
4.00	65.01	SLEEP LAB	0	0	0	0		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	682,365		5.00
6.00	13.00	NURSING ADMINISTRATION	0	0	0	3,548		6.00
7.00	50.00	OPERATING ROOM	0	0	0	0		7.00
8.00	90.00	CLINIC	0	0	0	0		8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,902,833		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet B
Part I
Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,638,895	1,638,895			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,410,061		2,410,061		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,126,482	15,314	22,520	4,164,316	4.00
5.01	00550	DATA PROCESSING	3,579,344	7,303	10,739	0	3,597,386
5.02	00560	PURCHASING RECEIVING AND STORES	48,914	7,218	10,615	11,804	10,581
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,279,358	21,672	31,870	134,732	190,450
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	5,138,145	325,334	478,416	256,687	306,836
6.00	00600	MAINTENANCE & REPAIRS	1,262,610	164,674	242,159	70,980	105,805
7.00	00700	OPERATION OF PLANT	206,105	2,462	3,621	49,470	42,322
8.00	00800	LAUNDRY & LINEN SERVICE	266,224	11,367	16,716	0	0
9.00	00900	HOUSEKEEPING	463,268	11,047	16,245	87,599	21,161
10.00	01000	DIETARY	183,441	79,655	117,136	31,015	74,064
11.00	01100	CAFETERIA	256,635	7,927	11,657	65,125	0
13.00	01300	NURSING ADMINISTRATION	1,159,162	37,458	55,084	295,249	31,742
14.00	01400	CENTRAL SERVICES & SUPPLY	37,769	7,876	11,582	9,682	0
15.00	01500	PHARMACY	11,905,362	16,933	24,900	145,268	52,903
16.00	01600	MEDICAL RECORDS & LIBRARY	23,053	78,306	115,152	8,252	42,322
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,312,311	142,766	209,943	482,307	507,866
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,475,809	217,226	319,440	672,815	666,575
51.00	05100	RECOVERY ROOM	183,855	23,966	35,243	42,974	42,322
53.00	05300	ANESTHESIOLOGY	232,373	1,316	1,934	0	10,581
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,796,208	86,621	127,379	301,422	201,030
60.00	06000	LABORATORY	2,802,670	39,600	58,233	200,716	169,289
64.00	06400	INTRAVENOUS THERAPY	904,026	46,886	68,947	192,680	222,191
65.00	06500	RESPIRATORY THERAPY	770,155	11,081	16,294	134,869	84,644
65.01	03610	SLEEP LAB	794,249	63,852	93,898	148,956	158,708
65.02	03620	GERIATRIC PSYCH	314,441	20,407	30,010	59,516	52,903
66.00	06600	PHYSICAL THERAPY	1,359,825	20,238	29,761	322,329	190,450
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	964,927	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,387,983	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	150,644	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	291,359	31,909	46,924	71,149	52,903
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	226,142	43,091	63,367	50,183	137,547
91.00	09100	EMERGENCY	2,130,681	80,060	117,732	318,537	222,191
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	57,082,486	1,623,565	2,387,517	4,164,316	3,597,386
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,370	10,838	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	46,767	0	0	0	0
192.01	19201	UNUSED SPACE	0	7,960	11,706	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	57,129,253	1,638,895	2,410,061	4,164,316	3,597,386

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet B
Part I
Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description			PURCHASING RECEIVING AND STORES	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	89,132					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	422	1,658,504				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	167	0	6,505,585	6,505,585		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,846,228	237,257	2,083,485	6.00
7.00	00700	OPERATION OF PLANT	0	0	303,980	39,064	4,675	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	294,307	37,821	21,582	8.00
9.00	00900	HOUSEKEEPING	16	0	599,336	77,020	20,973	9.00
10.00	01000	DIETARY	17	0	485,328	62,369	151,233	10.00
11.00	01100	CAFETERIA	43	0	341,387	43,871	15,050	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,578,695	202,877	71,118	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1	0	66,910	8,599	14,954	14.00
15.00	01500	PHARMACY	778	0	12,146,144	1,560,874	32,149	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	267,085	34,323	148,672	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,687	21,459	4,684,339	601,980	271,054	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	24,623	403,708	6,780,196	871,316	412,424	50.00
51.00	05100	RECOVERY ROOM	127	10,423	338,910	43,553	45,501	51.00
53.00	05300	ANESTHESIOLOGY	1,894	60,405	308,503	39,645	2,498	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,621	326,026	2,841,307	365,134	164,458	54.00
60.00	06000	LABORATORY	20,326	277,398	3,568,232	458,550	75,184	60.00
64.00	06400	INTRAVENOUS THERAPY	5,276	25,795	1,465,801	188,369	89,017	64.00
65.00	06500	RESPIRATORY THERAPY	520	31,815	1,049,378	134,855	21,038	65.00
65.01	03610	SLEEP LAB	157	50,419	1,310,239	168,378	121,230	65.01
65.02	03620	GERIATRIC PSYCH	4	4,590	481,871	61,925	38,745	65.02
66.00	06600	PHYSICAL THERAPY	462	60,070	1,983,135	254,851	38,425	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,076	33,125	1,012,128	130,068	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	42,254	2,430,237	312,307	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	196,739	347,383	44,642	0	73.00
76.97	07697	CARDIAC REHABILITATION	145	7,690	502,079	64,522	60,583	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	672	12,488	533,490	68,558	81,813	90.00
91.00	09100	EMERGENCY	9,098	94,100	2,972,399	381,980	152,002	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	89,132	1,658,504	57,044,612	6,494,708	2,054,378	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	18,208	2,340	13,993	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	46,767	6,010	0	192.00
192.01	19201	UNUSED SPACE	0	0	19,666	2,527	15,114	192.01
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)	89,132	1,658,504	57,129,253	6,505,585	2,083,485	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet B
Part I
Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT	347,719				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,610	357,320			8.00
9.00	00900	HOUSEKEEPING	3,508	1,107	701,944		9.00
10.00	01000	DIETARY	25,297	63	0	724,290	10.00
11.00	01100	CAFETERIA	2,517	0	10,066	0	11.00
13.00	01300	NURSING ADMINISTRATION	11,896	0	0	412,891	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,501	0	0	0	14.00
15.00	01500	PHARMACY	5,377	0	6,571	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24,868	0	1,678	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	45,339	135,260	219,209	724,290	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	68,984	40,357	162,729	0	50.00
51.00	05100	RECOVERY ROOM	7,611	13,882	9,926	0	51.00
53.00	05300	ANESTHESIOLOGY	418	0	419	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,509	46,362	33,552	0	54.00
60.00	06000	LABORATORY	12,576	0	8,248	0	60.00
64.00	06400	INTRAVENOUS THERAPY	14,890	0	49,630	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,519	1,035	5,033	0	65.00
65.01	03610	SLEEP LAB	20,278	360	16,776	0	65.01
65.02	03620	GERIATRIC PSYCH	6,481	0	8,668	0	65.02
66.00	06600	PHYSICAL THERAPY	6,427	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	10,134	333	8,388	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	13,685	3,826	25,164	0	90.00
91.00	09100	EMERGENCY	25,425	114,735	135,887	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	342,850	357,320	701,944	724,290	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,341	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	2,528	0	0	0	192.01
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)	347,719	357,320	701,944	724,290	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet B
Part I
Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,891,490					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	95,494				14.00
15.00	01500	PHARMACY	0	0	13,765,696			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	479,074		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	633,387	0	17,407	6,200	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	633,179	0	28,627	116,508	0	50.00
51.00	05100	RECOVERY ROOM	66,876	0	715	3,012	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	3,054	17,454	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,606	94,203	0	54.00
60.00	06000	LABORATORY	0	0	0	80,153	0	60.00
64.00	06400	INTRAVENOUS THERAPY	175,147	0	15,404	7,453	0	64.00
65.00	06500	RESPIRATORY THERAPY	21,693	0	0	9,193	0	65.00
65.01	03610	SLEEP LAB	0	0	0	14,568	0	65.01
65.02	03620	GERIATRIC PSYCH	18,040	0	0	1,326	0	65.02
66.00	06600	PHYSICAL THERAPY	0	0	150	17,357	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	95,494	0	9,571	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,209	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	13,675,330	56,847	0	73.00
76.97	07697	CARDIAC REHABILITATION	20,045	0	0	2,222	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	32,577	0	4,327	3,608	0	90.00
91.00	09100	EMERGENCY	290,546	0	19,076	27,190	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,891,490	95,494	13,765,696	479,074	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
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)	1,891,490	95,494	13,765,696	479,074	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet B
Part I
Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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	00550	DATA PROCESSING				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL				5.04
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,404,923	0	7,404,923	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,196,581	0	9,196,581	50.00
51.00	05100	RECOVERY ROOM	535,889	0	535,889	51.00
53.00	05300	ANESTHESIOLOGY	371,991	0	371,991	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,610,475	0	3,610,475	54.00
60.00	06000	LABORATORY	4,234,553	0	4,234,553	60.00
64.00	06400	INTRAVENOUS THERAPY	2,023,094	0	2,023,094	64.00
65.00	06500	RESPIRATORY THERAPY	1,263,889	0	1,263,889	65.00
65.01	03610	SLEEP LAB	1,672,367	0	1,672,367	65.01
65.02	03620	GERIATRIC PSYCH	624,401	0	624,401	65.02
66.00	06600	PHYSICAL THERAPY	2,335,927	0	2,335,927	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,247,261	0	1,247,261	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,754,753	0	2,754,753	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,124,202	0	14,124,202	73.00
76.97	07697	CARDIAC REHABILITATION	677,120	0	677,120	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	772,761	0	772,761	90.00
91.00	09100	EMERGENCY	4,149,572	0	4,149,572	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,999,759	0	56,999,759	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	36,882	0	36,882	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	52,777	0	52,777	192.00
192.01	19201	UNUSED SPACE	39,835	0	39,835	192.01
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	57,129,253	0	57,129,253	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-1334

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

Worksheet Non-CMS W

Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.01	DATA PROCESSING	5	NUMBER OF PCS	5.01
5.02	PURCHASING RECEIVING AND STORES	6	PURCHASING SUPPLIES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	7	GROSS REVENUE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	-5	ACCUM. COST	5.04
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	9	HOURS OF SERVICE	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	11	NUMBER OF FTES	11.00
13.00	NURSING ADMINISTRATION	13	DIRECT NURS. HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	7	GROSS REVENUE	16.00
19.00	NONPHYSICIAN ANESTHETISTS	19	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet B
Part II
Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	15,314	22,520	37,834	4.00
5.01	00550	DATA PROCESSING	0	7,303	10,739	18,042	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	7,218	10,615	17,833	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	21,672	31,870	53,542	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	325,334	478,416	803,750	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	164,674	242,159	406,833	6.00
7.00	00700	OPERATION OF PLANT	0	2,462	3,621	6,083	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,367	16,716	28,083	8.00
9.00	00900	HOUSEKEEPING	0	11,047	16,245	27,292	9.00
10.00	01000	DIETARY	0	79,655	117,136	196,791	10.00
11.00	01100	CAFETERIA	0	7,927	11,657	19,584	11.00
13.00	01300	NURSING ADMINISTRATION	0	37,458	55,084	92,542	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,876	11,582	19,458	14.00
15.00	01500	PHARMACY	0	16,933	24,900	41,833	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	78,306	115,152	193,458	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	142,766	209,943	352,709	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	217,226	319,440	536,666	50.00
51.00	05100	RECOVERY ROOM	0	23,966	35,243	59,209	51.00
53.00	05300	ANESTHESIOLOGY	0	1,316	1,934	3,250	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	86,621	127,379	214,000	54.00
60.00	06000	LABORATORY	0	39,600	58,233	97,833	60.00
64.00	06400	INTRAVENOUS THERAPY	0	46,886	68,947	115,833	64.00
65.00	06500	RESPIRATORY THERAPY	0	11,081	16,294	27,375	65.00
65.01	03610	SLEEP LAB	0	63,852	93,898	157,750	65.01
65.02	03620	GERIATRIC PSYCH	0	20,407	30,010	50,417	65.02
66.00	06600	PHYSICAL THERAPY	0	20,238	29,761	49,999	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	31,909	46,924	78,833	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	43,091	63,367	106,458	90.00
91.00	09100	EMERGENCY	0	80,060	117,732	197,792	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,623,565	2,387,517	4,011,082	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,370	10,838	18,208	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	0	7,960	11,706	19,666	192.01
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,638,895	2,410,061	4,048,956	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet B
Part II
Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.01	5.02	5.03	5.04	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING	18,042					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	53	17,993				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	955	85	55,806			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	1,539	34	0	807,655		5.04
6.00	00600	MAINTENANCE & REPAIRS	531	0	0	29,455	437,464	6.00
7.00	00700	OPERATION OF PLANT	212	0	0	4,850	982	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	4,695	4,531	8.00
9.00	00900	HOUSEKEEPING	106	3	0	9,562	4,404	9.00
10.00	01000	DIETARY	371	3	0	7,743	31,754	10.00
11.00	01100	CAFETERIA	0	9	0	5,446	3,160	11.00
13.00	01300	NURSING ADMINISTRATION	159	0	0	25,187	14,932	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,067	3,140	14.00
15.00	01500	PHARMACY	265	157	0	193,785	6,750	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	212	0	0	4,261	31,216	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,547	1,552	723	74,734	56,913	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,346	4,970	13,542	108,171	86,598	50.00
51.00	05100	RECOVERY ROOM	212	26	351	5,407	9,554	51.00
53.00	05300	ANESTHESIOLOGY	53	382	2,035	4,922	524	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,008	529	10,981	45,330	34,531	54.00
60.00	06000	LABORATORY	849	4,103	9,343	56,928	15,786	60.00
64.00	06400	INTRAVENOUS THERAPY	1,114	1,065	869	23,385	18,691	64.00
65.00	06500	RESPIRATORY THERAPY	425	105	1,072	16,742	4,417	65.00
65.01	03610	SLEEP LAB	796	32	1,698	20,904	25,454	65.01
65.02	03620	GERIATRIC PSYCH	265	1	155	7,688	8,135	65.02
66.00	06600	PHYSICAL THERAPY	955	93	2,023	31,639	8,068	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,842	1,116	16,147	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,423	38,772	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	6,626	5,542	0	73.00
76.97	07697	CARDIAC REHABILITATION	265	29	259	8,010	12,720	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	690	136	421	8,511	17,178	90.00
91.00	09100	EMERGENCY	1,114	1,837	3,169	47,422	31,915	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,042	17,993	55,806	806,305	431,353	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	290	2,938	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	746	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	314	3,173	192.01
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)	18,042	17,993	55,806	807,655	437,464	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet B
Part II
Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	12,576					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	131	37,440				8.00
9.00	00900	HOUSEKEEPING	127	116	42,406			9.00
10.00	01000	DIETARY	915	7	0	237,866		10.00
11.00	01100	CAFETERIA	91	0	608	0	29,490	11.00
13.00	01300	NURSING ADMINISTRATION	430	0	0	0	1,922	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	90	0	0	0	181	14.00
15.00	01500	PHARMACY	194	0	397	0	1,041	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	899	0	101	0	175	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,640	14,171	13,244	237,866	4,747	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,496	4,229	9,831	0	5,873	50.00
51.00	05100	RECOVERY ROOM	275	1,455	600	0	422	51.00
53.00	05300	ANESTHESIOLOGY	15	0	25	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	995	4,858	2,027	0	2,596	54.00
60.00	06000	LABORATORY	455	0	498	0	2,258	60.00
64.00	06400	INTRAVENOUS THERAPY	539	0	2,998	0	1,242	64.00
65.00	06500	RESPIRATORY THERAPY	127	108	304	0	1,296	65.00
65.01	03610	SLEEP LAB	733	38	1,013	0	1,467	65.01
65.02	03620	GERIATRIC PSYCH	234	0	524	0	525	65.02
66.00	06600	PHYSICAL THERAPY	232	0	0	0	2,541	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	367	35	507	0	630	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	495	401	1,520	0	408	90.00
91.00	09100	EMERGENCY	920	12,022	8,209	0	2,166	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,400	37,440	42,406	237,866	29,490	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	85	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	91	0	0	0	0	192.01
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)	12,576	37,440	42,406	237,866	29,490	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet B
Part II
Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	137,854					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	24,024				14.00
15.00	01500	PHARMACY	0	0	245,742			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	230,397		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	46,162	0	311	2,981		30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	46,147	0	511	56,061		50.00
51.00	05100	RECOVERY ROOM	4,874	0	13	1,448		51.00
53.00	05300	ANESTHESIOLOGY	0	0	55	8,392		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	29	45,297		54.00
60.00	06000	LABORATORY	0	0	0	38,541		60.00
64.00	06400	INTRAVENOUS THERAPY	12,765	0	275	3,584		64.00
65.00	06500	RESPIRATORY THERAPY	1,581	0	0	4,420		65.00
65.01	03610	SLEEP LAB	0	0	0	7,005		65.01
65.02	03620	GERIATRIC PSYCH	1,315	0	0	638		65.02
66.00	06600	PHYSICAL THERAPY	0	0	3	8,346		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	24,024	0	4,602		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,871		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	244,127	27,334		73.00
76.97	07697	CARDIAC REHABILITATION	1,461	0	0	1,068		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0		77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,374	0	77	1,735		90.00
91.00	09100	EMERGENCY	21,175	0	341	13,074		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	137,854	24,024	245,742	230,397	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	UNUSED SPACE	0	0	0	0		192.01
200.00		Cross Foot Adjustments						0200.00
201.00		Negative Cost Centers	0	0	0	0		0201.00
202.00		TOTAL (sum lines 118 through 201)	137,854	24,024	245,742	230,397	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet B
Part II
Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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	00550	DATA PROCESSING				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL				5.04
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	814,682	0	814,682	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	884,554	0	884,554	50.00
51.00	05100	RECOVERY ROOM	84,236	0	84,236	51.00
53.00	05300	ANESTHESIOLOGY	19,653	0	19,653	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	364,920	0	364,920	54.00
60.00	06000	LABORATORY	228,418	0	228,418	60.00
64.00	06400	INTRAVENOUS THERAPY	184,111	0	184,111	64.00
65.00	06500	RESPIRATORY THERAPY	59,197	0	59,197	65.00
65.01	03610	SLEEP LAB	218,243	0	218,243	65.01
65.02	03620	GERIATRIC PSYCH	70,438	0	70,438	65.02
66.00	06600	PHYSICAL THERAPY	106,827	0	106,827	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	48,731	0	48,731	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46,066	0	46,066	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	283,629	0	283,629	73.00
76.97	07697	CARDIAC REHABILITATION	104,830	0	104,830	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	140,860	0	140,860	90.00
91.00	09100	EMERGENCY	344,050	0	344,050	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,003,445	0	4,003,445	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,521	0	21,521	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	746	0	746	192.00
192.01	19201	UNUSED SPACE	23,244	0	23,244	192.01
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,048,956	0	4,048,956	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1334

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

Worksheet B-1

Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (NUMBER OF PCS)	PURCHASING RECEIVING AND STORES (PURCHASING SUPPLIES)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	97,175					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		97,175				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	908	908	16,230,935			4.00
5.01	00550	DATA PROCESSING	433	433	0	340		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	428	428	46,006	1	2,209,655	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,285	1,285	525,135	18	10,456	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	19,290	19,290	1,000,469	29	4,130	5.04
6.00	00600	MAINTENANCE & REPAIRS	9,764	9,764	276,652	10	0	6.00
7.00	00700	OPERATION OF PLANT	146	146	192,816	4	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	674	674	0	0	0	8.00
9.00	00900	HOUSEKEEPING	655	655	341,428	2	403	9.00
10.00	01000	DIETARY	4,723	4,723	120,886	7	419	10.00
11.00	01100	CAFETERIA	470	470	253,834	0	1,072	11.00
13.00	01300	NURSING ADMINISTRATION	2,221	2,221	1,150,769	3	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	467	467	37,735	0	16	14.00
15.00	01500	PHARMACY	1,004	1,004	566,199	5	19,286	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,643	4,643	32,163	4	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,465	8,465	1,879,849	48	190,567	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,880	12,880	2,622,395	63	610,451	50.00
51.00	05100	RECOVERY ROOM	1,421	1,421	167,495	4	3,148	51.00
53.00	05300	ANESTHESIOLOGY	78	78	0	1	46,953	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,136	5,136	1,174,828	19	64,966	54.00
60.00	06000	LABORATORY	2,348	2,348	782,315	16	503,900	60.00
64.00	06400	INTRAVENOUS THERAPY	2,780	2,780	750,992	21	130,802	64.00
65.00	06500	RESPIRATORY THERAPY	657	657	525,667	8	12,890	65.00
65.01	03610	SLEEP LAB	3,786	3,786	580,573	15	3,902	65.01
65.02	03620	GERIATRIC PSYCH	1,210	1,210	231,971	5	90	65.02
66.00	06600	PHYSICAL THERAPY	1,200	1,200	1,256,315	18	11,449	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	348,961	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	1,892	1,892	277,313	5	3,599	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,555	2,555	195,596	13	16,649	90.00
91.00	09100	EMERGENCY	4,747	4,747	1,241,534	21	225,546	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	96,266	96,266	16,230,935	340	2,209,655	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	437	437	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	472	472	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,638,895	2,410,061	4,164,316	3,597,386	89,132	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.865397	24.801245	0.256567	10,580.547059	0.040338	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			37,834	18,042	17,993	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002331	53.064706	0.008143	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: 14-1334

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

Worksheet B-1

Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description			CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5A.04	5.04	6.00	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	258,608,241					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	-6,505,585	50,623,668			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,846,228	65,067		6.00
7.00	00700	OPERATION OF PLANT	0	0	303,980	146	64,921	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	294,307	674	674	8.00
9.00	00900	HOUSEKEEPING	0	0	599,336	655	655	9.00
10.00	01000	DIETARY	0	0	485,328	4,723	4,723	10.00
11.00	01100	CAFETERIA	0	0	341,387	470	470	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,578,695	2,221	2,221	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	66,910	467	467	14.00
15.00	01500	PHARMACY	0	0	12,146,144	1,004	1,004	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	267,085	4,643	4,643	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,346,157	0	4,684,339	8,465	8,465	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	62,943,748	0	6,780,196	12,880	12,880	50.00
51.00	05100	RECOVERY ROOM	1,625,370	0	338,910	1,421	1,421	51.00
53.00	05300	ANESTHESIOLOGY	9,419,163	0	308,503	78	78	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,838,269	0	2,841,307	5,136	5,136	54.00
60.00	06000	LABORATORY	43,255,628	0	3,568,232	2,348	2,348	60.00
64.00	06400	INTRAVENOUS THERAPY	4,022,245	0	1,465,801	2,780	2,780	64.00
65.00	06500	RESPIRATORY THERAPY	4,961,038	0	1,049,378	657	657	65.00
65.01	03610	SLEEP LAB	7,861,940	0	1,310,239	3,786	3,786	65.01
65.02	03620	GERIATRIC PSYCH	715,750	0	481,871	1,210	1,210	65.02
66.00	06600	PHYSICAL THERAPY	9,366,885	0	1,983,135	1,200	1,200	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,165,323	0	1,012,128	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,588,730	0	2,430,237	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,678,154	0	347,383	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,199,123	0	502,079	1,892	1,892	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,947,341	0	533,490	2,555	2,555	90.00
91.00	09100	EMERGENCY	14,673,377	0	2,972,399	4,747	4,747	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	258,608,241	-6,505,585	50,539,027	64,158	64,012	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	18,208	437	437	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	46,767	0	0	192.00
192.01	19201	UNUSED SPACE	0	0	19,666	472	472	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,658,504		6,505,585	2,083,485	347,719	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.006413		0.128509	32.020610	5.356033	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	55,806		807,655	437,464	12,576	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000216		0.015954	6.723285	0.193712	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: 14-1334

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

Worksheet B-1

Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description			LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER OF FTES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	39,692					8.00
9.00	00900	HOUSEKEEPING	123	5,021				9.00
10.00	01000	DIETARY	7	0	17,827			10.00
11.00	01100	CAFETERIA	0	72	0	15,178		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	989	127,390	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	93	0	14.00
15.00	01500	PHARMACY	0	47	0	536	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12	0	90	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,025	1,568	17,827	2,443	42,658	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,483	1,164	0	3,024	42,644	50.00
51.00	05100	RECOVERY ROOM	1,542	71	0	217	4,504	51.00
53.00	05300	ANESTHESIOLOGY	0	3	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,150	240	0	1,336	0	54.00
60.00	06000	LABORATORY	0	59	0	1,162	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	355	0	639	11,796	64.00
65.00	06500	RESPIRATORY THERAPY	115	36	0	667	1,461	65.00
65.01	03610	SLEEP LAB	40	120	0	755	0	65.01
65.02	03620	GERIATRIC PSYCH	0	62	0	270	1,215	65.02
66.00	06600	PHYSICAL THERAPY	0	0	0	1,308	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	37	60	0	324	1,350	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	425	180	0	210	2,194	90.00
91.00	09100	EMERGENCY	12,745	972	0	1,115	19,568	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,692	5,021	17,827	15,178	127,390	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
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)	357,320	701,944	724,290	412,891	1,891,490	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.002318	139.801633	40.628821	27.203255	14.848026	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	37,440	42,406	237,866	29,490	137,854	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.943263	8.445728	13.343019	1.942944	1.082141	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: 14-1334

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

Worksheet B-1

Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description			CENTRAL SERVICES & SUPPLY (COSTED REQUIRE)	PHARMACY (COSTED REQUIRE)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	964,927				14.00
15.00	01500	PHARMACY	0	11,226,882			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	258,608,241		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	14,197	3,346,157	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	23,347	62,943,748	0	50.00
51.00	05100	RECOVERY ROOM	0	583	1,625,370	0	51.00
53.00	05300	ANESTHESIOLOGY	0	2,491	9,419,163	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,310	50,838,269	0	54.00
60.00	06000	LABORATORY	0	0	43,255,628	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	12,563	4,022,245	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	4,961,038	0	65.00
65.01	03610	SLEEP LAB	0	0	7,861,940	0	65.01
65.02	03620	GERIATRIC PSYCH	0	0	715,750	0	65.02
66.00	06600	PHYSICAL THERAPY	0	122	9,366,885	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	964,927	0	5,165,323	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	6,588,730	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,153,182	30,678,154	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	1,199,123	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	3,529	1,947,341	0	90.00
91.00	09100	EMERGENCY	0	15,558	14,673,377	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	964,927	11,226,882	258,608,241	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	192.01
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)	95,494	13,765,696	479,074	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.098965	1.226137	0.001853	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	24,024	245,742	230,397	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.024897	0.021889	0.000891	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: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet C
Part I
Date/Time Prepared:
8/29/2023 11:22 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	7,404,923		7,404,923	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,196,581		9,196,581	0	0	50.00
51.00	05100	RECOVERY ROOM	535,889		535,889	0	0	51.00
53.00	05300	ANESTHESIOLOGY	371,991		371,991	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,610,475		3,610,475	0	0	54.00
60.00	06000	LABORATORY	4,234,553		4,234,553	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	2,023,094		2,023,094	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,263,889	0	1,263,889	0	0	65.00
65.01	03610	SLEEP LAB	1,672,367	0	1,672,367	0	0	65.01
65.02	03620	GERIATRIC PSYCH	624,401	0	624,401	0	0	65.02
66.00	06600	PHYSICAL THERAPY	2,335,927	0	2,335,927	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,247,261		1,247,261	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,754,753		2,754,753	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,124,202		14,124,202	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	677,120		677,120	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	772,761		772,761	0	0	90.00
91.00	09100	EMERGENCY	4,149,572		4,149,572	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	507,864		507,864		0	92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	57,507,623	0	57,507,623	0	0	200.00
201.00		Less Observation Beds	507,864		507,864		0	201.00
202.00		Total (see instructions)	56,999,759	0	56,999,759	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet C
Part I
Date/Time Prepared:
8/29/2023 11:22 am

			Title XVIII			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,882,772		2,882,772			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	89,228	62,854,520	62,943,748	0.146108	0.000000	50.00
51.00	05100	RECOVERY ROOM	9,040	1,616,330	1,625,370	0.329703	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	16,512	9,402,651	9,419,163	0.039493	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	832,926	50,005,343	50,838,269	0.071019	0.000000	54.00
60.00	06000	LABORATORY	1,416,153	41,839,475	43,255,628	0.097896	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	125,112	3,897,133	4,022,245	0.502976	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,203,016	3,758,021	4,961,037	0.254763	0.000000	65.00
65.01	03610	SLEEP LAB	0	7,861,940	7,861,940	0.212717	0.000000	65.01
65.02	03620	GERIATRIC PSYCH	0	715,750	715,750	0.872373	0.000000	65.02
66.00	06600	PHYSICAL THERAPY	2,536,388	6,830,497	9,366,885	0.249381	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	126,188	5,039,135	5,165,323	0.241468	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,950	6,586,780	6,588,730	0.418101	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,105,506	28,572,647	30,678,153	0.460399	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,199,123	1,199,123	0.564679	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,000	1,946,341	1,947,341	0.396829	0.000000	90.00
91.00	09100	EMERGENCY	296,777	14,376,600	14,673,377	0.282796	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,749	455,636	463,385	1.095987	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	11,650,317	246,957,922	258,608,239			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,650,317	246,957,922	258,608,239			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet C
Part I
Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		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
51.00	05100 RECOVERY ROOM	0.000000			51.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
65.01	03610 SLEEP LAB	0.000000			65.01
65.02	03620 GERIATRIC PSYCH	0.000000			65.02
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000			77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
102.00	10200 OPIOID TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet C
Part I
Date/Time Prepared:
8/29/2023 11:22 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	7,404,923		7,404,923	0	7,404,923	30.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,196,581		9,196,581	0	9,196,581	50.00	
51.00	05100	RECOVERY ROOM	535,889		535,889	0	535,889	51.00	
53.00	05300	ANESTHESIOLOGY	371,991		371,991	0	371,991	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,610,475		3,610,475	0	3,610,475	54.00	
60.00	06000	LABORATORY	4,234,553		4,234,553	0	4,234,553	60.00	
64.00	06400	INTRAVENOUS THERAPY	2,023,094		2,023,094	0	2,023,094	64.00	
65.00	06500	RESPIRATORY THERAPY	1,263,889	0	1,263,889	0	1,263,889	65.00	
65.01	03610	SLEEP LAB	1,672,367	0	1,672,367	0	1,672,367	65.01	
65.02	03620	GERIATRIC PSYCH	624,401	0	624,401	0	624,401	65.02	
66.00	06600	PHYSICAL THERAPY	2,335,927	0	2,335,927	0	2,335,927	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,247,261		1,247,261	0	1,247,261	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,754,753		2,754,753	0	2,754,753	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	14,124,202		14,124,202	0	14,124,202	73.00	
76.97	07697	CARDIAC REHABILITATION	677,120		677,120	0	677,120	76.97	
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	772,761		772,761	0	772,761	90.00	
91.00	09100	EMERGENCY	4,149,572		4,149,572	0	4,149,572	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	507,864		507,864		507,864	92.00	
	OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	57,507,623	0	57,507,623	0	57,507,623	200.00	
201.00		Less Observation Beds	507,864		507,864		507,864	201.00	
202.00		Total (see instructions)	56,999,759	0	56,999,759	0	56,999,759	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet C
Part I
Date/Time Prepared:
8/29/2023 11:22 am

			Title XIX			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,882,772		2,882,772			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	89,228	62,854,520	62,943,748	0.146108	0.000000	50.00
51.00	05100	RECOVERY ROOM	9,040	1,616,330	1,625,370	0.329703	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	16,512	9,402,651	9,419,163	0.039493	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	832,926	50,005,343	50,838,269	0.071019	0.000000	54.00
60.00	06000	LABORATORY	1,416,153	41,839,475	43,255,628	0.097896	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	125,112	3,897,133	4,022,245	0.502976	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,203,016	3,758,021	4,961,037	0.254763	0.000000	65.00
65.01	03610	SLEEP LAB	0	7,861,940	7,861,940	0.212717	0.000000	65.01
65.02	03620	GERIATRIC PSYCH	0	715,750	715,750	0.872373	0.000000	65.02
66.00	06600	PHYSICAL THERAPY	2,536,388	6,830,497	9,366,885	0.249381	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	126,188	5,039,135	5,165,323	0.241468	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,950	6,586,780	6,588,730	0.418101	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,105,506	28,572,647	30,678,153	0.460399	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,199,123	1,199,123	0.564679	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,000	1,946,341	1,947,341	0.396829	0.000000	90.00
91.00	09100	EMERGENCY	296,777	14,376,600	14,673,377	0.282796	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,749	455,636	463,385	1.095987	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	11,650,317	246,957,922	258,608,239			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,650,317	246,957,922	258,608,239			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet C
Part I
Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
65.01	03610 SLEEP LAB	0.000000			65.01
65.02	03620 GERIATRIC PSYCH	0.000000			65.02
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000			77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
102.00	10200 OPIOID TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet D
Part II
Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description			Title XVIII		Hospital	Cost	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	884,554	62,943,748	0.014053	38,367	539
51.00	05100	RECOVERY ROOM	84,236	1,625,370	0.051826	9,040	469
53.00	05300	ANESTHESIOLOGY	19,653	9,419,163	0.002086	9,162	19
54.00	05400	RADIOLOGY-DIAGNOSTIC	364,920	50,838,269	0.007178	150,607	1,081
60.00	06000	LABORATORY	228,418	43,255,628	0.005281	307,668	1,625
64.00	06400	INTRAVENOUS THERAPY	184,111	4,022,245	0.045773	25,394	1,162
65.00	06500	RESPIRATORY THERAPY	59,197	4,961,037	0.011932	205,627	2,454
65.01	03610	SLEEP LAB	218,243	7,861,940	0.027759	0	0
65.02	03620	GERIATRIC PSYCH	70,438	715,750	0.098411	0	0
66.00	06600	PHYSICAL THERAPY	106,827	9,366,885	0.011405	141,558	1,614
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	48,731	5,165,323	0.009434	22,108	209
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46,066	6,588,730	0.006992	650	5
73.00	07300	DRUGS CHARGED TO PATIENTS	283,629	30,678,153	0.009245	302,390	2,796
76.97	07697	CARDIAC REHABILITATION	104,830	1,199,123	0.087422	0	0
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	140,860	1,947,341	0.072335	0	0
91.00	09100	EMERGENCY	344,050	14,673,377	0.023447	6,157	144
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	55,875	463,385	0.120580	0	0
200.00		Total (lines 50 through 199)	3,244,638	255,725,467		1,218,728	12,117

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1334		Period: From 04/01/2022 To 03/31/2023		Worksheet D Part IV Date/Time Prepared: 8/29/2023 11:22 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
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
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	03610	SLEEP LAB		0	0	0	0	0	65.01
65.02	03620	GERIATRIC PSYCH		0	0	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1334		Period: From 04/01/2022 To 03/31/2023		Worksheet D Part IV Date/Time Prepared: 8/29/2023 11:22 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	62,943,748	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,625,370	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	9,419,163	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	50,838,269	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	43,255,628	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	4,022,245	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,961,037	0.000000	65.00
65.01	03610	SLEEP LAB	0	0	0	7,861,940	0.000000	65.01
65.02	03620	GERIATRIC PSYCH	0	0	0	715,750	0.000000	65.02
66.00	06600	PHYSICAL THERAPY	0	0	0	9,366,885	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,165,323	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,588,730	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	30,678,153	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,199,123	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	1,947,341	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	14,673,377	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	463,385	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	255,725,467		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet D
Part IV
Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description			Title XVIII		Hospital		Cost	
			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	38,367	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	9,040	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	9,162	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	150,607	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	307,668	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	25,394	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	205,627	0	0	0	65.00
65.01	03610	SLEEP LAB	0.000000	0	0	0	0	65.01
65.02	03620	GERIATRIC PSYCH	0.000000	0	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.000000	141,558	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	22,108	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	650	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	302,390	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	6,157	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,218,728	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet D
Part IV
Date/Time Prepared:
8/29/2023 11:22 am

				Title XVIII		Hospital		Cost	
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost					
			21.00	24.00					
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
60.00	06000	LABORATORY	0	0					60.00
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
65.01	03610	SLEEP LAB	0	0					65.01
65.02	03620	GERIATRIC PSYCH	0	0					65.02
66.00	06600	PHYSICAL THERAPY	0	0					66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0					77.00
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					92.00
200.00		Total (lines 50 through 199)	0	0					200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet D
Part V
Date/Time Prepared:
8/29/2023 11:22 am

				Title XVIII		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.146108	0	16,991,180	0	0	50.00	
51.00	05100	RECOVERY ROOM	0.329703	0	362,615	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	0.039493	0	2,395,617	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.071019	0	13,451,396	0	0	54.00	
60.00	06000	LABORATORY	0.097896	0	10,213,829	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0.502976	0	1,049,989	25,200	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.254763	0	1,155,183	0	0	65.00	
65.01	03610	SLEEP LAB	0.212717	0	1,643,183	0	0	65.01	
65.02	03620	GERIATRIC PSYCH	0.872373	0	375,801	0	0	65.02	
66.00	06600	PHYSICAL THERAPY	0.249381	0	1,532,280	0	0	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.241468	0	1,625,600	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.418101	0	2,172,419	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.460399	0	8,505,186	211	0	73.00	
76.97	07697	CARDIAC REHABILITATION	0.564679	0	503,920	0	0	76.97	
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.396829	0	616,353	0	0	90.00	
91.00	09100	EMERGENCY	0.282796	0	3,023,184	110,880	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.095987	0	0	0	0	92.00	
200.00		Subtotal (see instructions)		0	65,617,735	136,291	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	65,617,735	136,291	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet D
Part V
Date/Time Prepared:
8/29/2023 11:22 am

			Title XVIII		Hospital	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
			ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,482,547	0		50.00
51.00	05100	RECOVERY ROOM	119,555	0		51.00
53.00	05300	ANESTHESIOLOGY	94,610	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	955,305	0		54.00
60.00	06000	LABORATORY	999,893	0		60.00
64.00	06400	INTRAVENOUS THERAPY	528,119	12,675		64.00
65.00	06500	RESPIRATORY THERAPY	294,298	0		65.00
65.01	03610	SLEEP LAB	349,533	0		65.01
65.02	03620	GERIATRIC PSYCH	327,839	0		65.02
66.00	06600	PHYSICAL THERAPY	382,122	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	392,530	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	908,291	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,915,779	97		73.00
76.97	07697	CARDIAC REHABILITATION	284,553	0		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	244,587	0		90.00
91.00	09100	EMERGENCY	854,944	31,356		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	13,134,505	44,128		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	13,134,505	44,128		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1334	Period: From 04/01/2022 To 03/31/2023	Worksheet D-1 Date/Time Prepared: 8/29/2023 11:22 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)		4,359	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,172	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)		892	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		2,159	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)		717	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		295	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)		16	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		413	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)		1,394	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)		531	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)		7,404,923	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)		59,460	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		3,225	25.00
26.00	Total swing-bed cost (see instructions)		5,279,145	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,125,778	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,125,778	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)		1,813.79	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		749,095	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)		749,095	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1334

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

Worksheet D-1

Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		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)					296,796	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					1,045,891	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)					2,528,423	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					963,122	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					3,491,545	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)					280	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,813.80	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					507,864	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1334

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

Worksheet D-1

Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description		Title XVIII		Hospital		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	814,682	7,404,923	0.110019	507,864	55,875	90.00
91.00	Nursing Program cost	0	7,404,923	0.000000	507,864	0	91.00
92.00	Allied health cost	0	7,404,923	0.000000	507,864	0	92.00
93.00	All other Medical Education	0	7,404,923	0.000000	507,864	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1334	Period: From 04/01/2022 To 03/31/2023	Worksheet D-3 Date/Time Prepared: 8/29/2023 11:22 am	
Cost Center Description			Title XVIII	Hospital	Cost	
			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		384,215		30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.146108	38,367	5,606	50.00
51.00	05100	RECOVERY ROOM	0.329703	9,040	2,981	51.00
53.00	05300	ANESTHESIOLOGY	0.039493	9,162	362	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.071019	150,607	10,696	54.00
60.00	06000	LABORATORY	0.097896	307,668	30,119	60.00
64.00	06400	INTRAVENOUS THERAPY	0.502976	25,394	12,773	64.00
65.00	06500	RESPIRATORY THERAPY	0.254763	205,627	52,386	65.00
65.01	03610	SLEEP LAB	0.212717	0	0	65.01
65.02	03620	GERIATRIC PSYCH	0.872373	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.249381	141,558	35,302	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.241468	22,108	5,338	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.418101	650	272	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.460399	302,390	139,220	73.00
76.97	07697	CARDIAC REHABILITATION	0.564679	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.396829	0	0	90.00
91.00	09100	EMERGENCY	0.282796	6,157	1,741	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.095987	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,218,728	296,796	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)		1,218,728		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1334 Component CCN: 14-Z334	Period: From 04/01/2022 To 03/31/2023	Worksheet D-3 Date/Time Prepared: 8/29/2023 11:22 am	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		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	0.146108	0	0	50.00
51.00	05100 RECOVERY ROOM	0.329703	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.039493	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.071019	95,756	6,800	54.00
60.00	06000 LABORATORY	0.097896	225,107	22,037	60.00
64.00	06400 INTRAVENOUS THERAPY	0.502976	12,017	6,044	64.00
65.00	06500 RESPIRATORY THERAPY	0.254763	391,736	99,800	65.00
65.01	03610 SLEEP LAB	0.212717	0	0	65.01
65.02	03620 GERIATRIC PSYCH	0.872373	0	0	65.02
66.00	06600 PHYSICAL THERAPY	0.249381	1,367,029	340,911	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.241468	8,360	2,019	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.418101	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.460399	809,335	372,617	73.00
76.97	07697 CARDIAC REHABILITATION	0.564679	0	0	76.97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.396829	0	0	90.00
91.00	09100 EMERGENCY	0.282796	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.095987	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,909,340	850,228	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)		2,909,340		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1334 Component CCN: 14-Z334	Period: From 04/01/2022 To 03/31/2023	Worksheet D-3 Date/Time Prepared: 8/29/2023 11:22 am	
Cost Center Description		Title XIX	Swing Beds - SNF	Cost	
		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	0.146108	0	0	50.00
51.00	05100 RECOVERY ROOM	0.329703	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.039493	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.071019	0	0	54.00
60.00	06000 LABORATORY	0.097896	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.502976	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.254763	0	0	65.00
65.01	03610 SLEEP LAB	0.212717	0	0	65.01
65.02	03620 GERIATRIC PSYCH	0.872373	0	0	65.02
66.00	06600 PHYSICAL THERAPY	0.249381	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.241468	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.418101	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.460399	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0.564679	0	0	76.97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.396829	0	0	90.00
91.00	09100 EMERGENCY	0.282796	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.095987	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1334	Period: From 04/01/2022 To 03/31/2023	Worksheet E Part B Date/Time Prepared: 8/29/2023 11:22 am
		Title XVIII	Hospital	Cost
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		13,178,633	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)		13,178,633	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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		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)		13,310,419	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)		115,400	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		11,188,273	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)		2,006,746	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
28.50	REH facility payment amount		0	28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)		2,006,746	30.00
31.00	Primary payer payments		548	31.00
32.00	Subtotal (line 30 minus line 31)		2,006,198	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		1,930,324	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		1,254,711	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		911,663	36.00
37.00	Subtotal (see instructions)		3,260,909	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.75	N95 respirator payment adjustment amount (see instructions)		0	39.75
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,260,909	40.00
40.01	Sequestration adjustment (see instructions)		57,066	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		2,899,275	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		304,568	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1334	Period: From 04/01/2022 To 03/31/2023	Worksheet E Part B Date/Time Prepared: 8/29/2023 11:22 am	
		Title XVIII	Hospital	Cost	
				Overrides	
				1.00	
WORKSHEET OVERRIDE VALUES					
112.00	Override of Ancillary service charges (line 12)			0	112.00
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00	Part B Combined Billed Days			0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet E-1
Part I
Date/Time Prepared:
8/29/2023 11:22 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		847,775		2,704,374	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0	10/12/2022	182,372	3.01
3.02			0	11/30/2022	118,428	3.02
3.03		01/12/2023	10,934	01/12/2023	413,357	3.03
3.04		03/27/2023	68,433		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	11/30/2022	83,887		0	3.50
3.51			0	03/27/2023	519,256	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-4,520		194,901	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)		843,255		2,899,275	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		109,205		304,568	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		952,460		3,203,843	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: 14-1334

Period:

Worksheet E-1

Component CCN: 14-Z334

From 04/01/2022
To 03/31/2023Part I
Date/Time Prepared:
8/29/2023 11:22 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		3,900,195		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	11/30/2022	38,770		0	3.01
3.02		03/27/2023	517,364		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)		556,134		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)		4,456,329		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		218,019		0	6.02
7.00	Total Medicare program liability (see instructions)		4,238,310		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: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet E-1
Part II
Date/Time Prepared:
8/29/2023 11:22 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
				Overrides	
				1.00	
	CONTRACTOR OVERRIDES				
108.00	Override of HIT payment				108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1334

Period:

Worksheet E-2

Component CCN: 14-Z334

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

Date/Time Prepared:

8/29/2023 11:22 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)	3,526,460	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)	858,730	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	1,925	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)	4,385,190	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	4,385,190	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)	4,385,190	0	12.00	
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	72,444	0	13.00	
14.00	80% of Part B costs (line 12 x 80%)		0	14.00	
15.00	Subtotal (see instructions)	4,312,746	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)	1,625	0	17.00	
17.01	Adjusted reimbursable bad debts (see instructions)	1,056	0	17.01	
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00	
19.00	Total (see instructions)	4,313,802	0	19.00	
19.01	Sequestration adjustment (see instructions)	75,492	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	4,456,329	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)	-218,019	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	
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1334	Period: From 04/01/2022 To 03/31/2023	Worksheet E-2
		Component CCN: 14-Z334		Date/Time Prepared: 8/29/2023 11:22 am
		Title XIX	Swing Beds - SNF	Cost
			Part A	Part B
			1.00	2.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0	2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days		0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	8.00
9.00	Primary payer payments (see instructions)		0	9.00
10.00	Subtotal (line 8 minus line 9)		0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	11.00
12.00	Subtotal (line 10 minus line 11)		0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)		0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)		0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration		0	16.99
17.00	Allowable bad debts (see instructions)		0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	18.00
19.00	Total (see instructions)		0	19.00
19.01	Sequestration adjustment (see instructions)		0	19.01
19.02	Demonstration payment adjustment amount after sequestration		0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	19.25
20.00	Interim payments		0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)		0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)		0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison 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: 14-1334	Period: From 04/01/2022 To 03/31/2023	Worksheet E-3 Part V Date/Time Prepared: 8/29/2023 11:22 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,045,891	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
3.01	Cellular therapy acquisition cost (see instructions)		0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)		1,045,891	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,056,350	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		1,056,350	19.00
20.00	Deductibles (exclude professional component)		115,342	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		941,008	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		941,008	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		43,718	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		28,417	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		19,169	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		969,425	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)		969,425	30.00
30.01	Sequestration adjustment (see instructions)		16,965	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM			30.03
31.00	Interim payments		843,255	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)		109,205	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: 14-1334

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

Worksheet G

Date/Time Prepared:
8/29/2023 11:22 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	-1,672,641	0	1,350	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	27,684,196	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-18,297,572	0	0	0	6.00
7.00	Inventory	1,707,583	0	0	0	7.00
8.00	Prepaid expenses	135,306	0	0	0	8.00
9.00	Other current assets	81,201	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)	9,638,073	0	1,350	0	11.00
FIXED ASSETS						
12.00	Land	179,386	0	0	0	12.00
13.00	Land improvements	1,211,082	0	0	0	13.00
14.00	Accumulated depreciation	-953,780	0	0	0	14.00
15.00	Buildings	36,084,227	0	0	0	15.00
16.00	Accumulated depreciation	-20,040,067	0	0	0	16.00
17.00	Leasehold improvements	2,333	0	0	0	17.00
18.00	Accumulated depreciation	-719	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	127,114	0	0	0	21.00
22.00	Accumulated depreciation	-121,340	0	0	0	22.00
23.00	Major movable equipment	17,937,838	0	0	0	23.00
24.00	Accumulated depreciation	-13,604,903	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)	20,821,171	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	52,009	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	52,009	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	30,459,244	0	53,359	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,321,724	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	2,389,051	0	0	0	39.00
40.00	Notes and loans payable (short term)	249,315	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	3,504,871	0	0	0	43.00
44.00	Other current liabilities	394,427	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,859,388	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	13,035,070	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	327,628	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	13,362,698	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	21,222,086	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	9,237,158	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	53,359	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	9,237,158	0	53,359	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	30,459,244	0	53,359	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1334

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

Worksheet G-1

Date/Time Prepared:
8/29/2023 11:22 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		17,877,027		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-6,612,474				2.00
3.00	Total (sum of line 1 and line 2)		11,264,553		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	Contribution to Affiliates	-2,027,397		0		0	5.00
6.00	Restricted Donations	0		0		17,835	6.00
7.00	ROUNDING	2		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)		-2,027,395		0		10.00
11.00	Subtotal (line 3 plus line 10)		9,237,158		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	Restricted Grants	0		0		249,392	13.00
14.00	Restricted Donations	0		0		3,172	14.00
15.00	ROUNDING	0		0		1	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		9,237,158		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	288,089		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)	288,089		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	Contribution to Affiliates		0				5.00
6.00	Restricted Donations		0				6.00
7.00	ROUNDING		0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	17,835		0			10.00
11.00	Subtotal (line 3 plus line 10)	305,924		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	Restricted Grants		0				13.00
14.00	Restricted Donations		0				14.00
15.00	ROUNDING		0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	252,565		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	53,359		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1334

Period:
From 04/01/2022
To 03/31/2023Worksheet G-2
Parts I & II
Date/Time Prepared:
8/29/2023 11:22 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,346,638		1,346,638	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,536,134		1,536,134	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,882,772		2,882,772	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)	2,882,772		2,882,772	17.00
18.00	Ancillary services	8,461,143	230,180,222	238,641,365	18.00
19.00	Outpatient services	305,526	16,778,577	17,084,103	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	Other (specify)	0	0	0	27.00
27.99	EMPLOYEE INS AND WC CHARGES	0	8,175,692	8,175,692	27.99
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,649,441	255,134,491	266,783,932	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		56,895,526		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)		56,895,526		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1334

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

Worksheet G-3

Date/Time Prepared:
8/29/2023 11:22 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	266,783,932	1.00
2.00	Less contractual allowances and discounts on patients' accounts	180,772,224	2.00
3.00	Net patient revenues (line 1 minus line 2)	86,011,708	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	56,895,526	4.00
5.00	Net income from service to patients (line 3 minus line 4)	29,116,182	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	247,069	6.00
7.00	Income from investments	445,996	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	4,319	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	150,844	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	18,004	17.00
18.00	Revenue from sale of medical records and abstracts	9,139	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	5,238	22.00
23.00	Governmental appropriations	17,517	23.00
24.00	MISCELLANEOUS	119	24.00
24.50	COVID-19 PHE Funding	860,017	24.50
25.00	Total other income (sum of lines 6-24)	1,758,262	25.00
26.00	Total (line 5 plus line 25)	30,874,444	26.00
27.00	CORP ALLOC, CONTR, MISCELLANEOUS	37,486,918	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	37,486,918	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-6,612,474	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-1334	Period: From 04/01/2022 To 03/31/2023	Worksheet L Parts I-III Date/Time Prepared: 8/29/2023 11:22 am
		Title XVIII	Hospital	Cost
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		0	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		0.00	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		0	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00