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: 14-0034	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/21/2024 9:54 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/21/2024 Time: 9:54 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SSM HEALTH ST. MARYS HOSPITAL (14-0034) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 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	Eileen Lamm		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Eileen Lamm			2
3	Signatory Title	REGIONAL VP FINANCE			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-147,124	-3,321	0	0	1.00
2.00	SUBPROVIDER - IPF	0	26,606	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
12.30	OOT I	0		0		0	12.30
200.00	TOTAL	0	-120,518	-3,321	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/21/2024 9:54 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 400 NORTH PLEASANT AVENUE	PO Box:			1.00
2.00	City: CENTRALIA	State: IL	Zip Code: 62801-	County: MARION	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	SSM HEALTH ST. MARYS HOSPITAL	140034	99914	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF	SSM HEALTH ST. MARYS PSYCH	14S034	99914	4	01/01/2002	N	P	P	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.30	Hospital-Based (OOT) I	ST MARYS WORK SAFETY INSTITUTE	146668	99914		03/08/2000	N	O	N	17.30
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	1		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/21/2024 9:54 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	97	110	2	11	1,148	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	1		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.	01/01/2023	12/31/2023	38.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0034	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/21/2024 9:54 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/21/2024 9:54 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0034	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/21/2024 9:54 am

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/21/2024 9:54 am

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			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: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/21/2024 9:54 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	510,591	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.	N		123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB1798	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: SSM HEALTH	Contractor's Name: A	Contractor's Number: 05301	141.00
142.00	Street: 12800 COPORATE HILL DRIVE	PO Box:		142.00
143.00	City: ST. LOUIS	State: MO	Zip Code: 63301	143.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0034	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/21/2024 9:54 am

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	Y	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
161.01			N	N	N	161.01
161.30	OOT		N	N	N	161.30

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/21/2024 9:54 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/28/2024	Y	03/28/2024	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/21/2024 9:54 am

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JENNIFER	COHEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	SSM HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-989-3939	JENNIFER.COHEN@SSMHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0034	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/21/2024 9:54 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.	REGIONAL DIR GOV REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/21/2024 9:54 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	80	29,200	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		80	29,200	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		92	33,580	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF	40.00	24	8,760		0	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
25.30	CMHC - OOT	99.30				0	25.30
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)		116				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: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/21/2024 9:54 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)	4,526	91	7,986			1.00
2.00	HMO and other (see instructions)	1,465	1,271				2.00
3.00	HMO IPF Subprovider	30	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,526	91	7,986			7.00
8.00	INTENSIVE CARE UNIT	464	6	936			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		0	0			13.00
14.00	Total (see instructions)	4,990	97	8,922	0.00	384.77	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF	975	23	5,472	0.00	34.01	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
25.30	CMHC - OOT	0	0	0	0.00	0.00	25.30
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	418.78	27.00
28.00	Observation Bed Days		30	696			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			51			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: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/21/2024 9:54 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,204	31	3,321	1.00
2.00	HMO and other (see instructions)			405	454		2.00
3.00	HMO IPF Subprovider				492		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	1,204	31	3,321	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF	0.00	0	115	57	885	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
25.30	CMHC - OOT	0.00					25.30
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 5/21/2024 9:54 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	33,186,805	0	33,186,805	871,073.92	38.10	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		189,896	1,252	191,148	1,252.00	152.67	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		1,153,191	0	1,153,191	12,360.95	93.29	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,317,397	-119,606	3,197,791	82,015.47	38.99	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,144,896	0	3,144,896	30,748.06	102.28	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		96,600	0	96,600	496.33	194.63	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		4,668,671	0	4,668,671	76,245.21	61.23	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		13,778,389	0	13,778,389			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		1,434,414	0	1,434,414			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		21,897	0	21,897			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		1,653,257	0	1,653,257			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 5/21/2024 9:54 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	180,008	0	180,008	12,035.89	14.96	26.00
27.00	Administrative & General	5.00	3,300,906	0	3,300,906	77,050.22	42.84	27.00
28.00	Administrative & General under contract (see inst.)		453,251	0	453,251	2,408.44	188.19	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	834,133	0	834,133	28,974.28	28.79	30.00
31.00	Laundry & Linen Service	8.00	91,574	0	91,574	4,899.13	18.69	31.00
32.00	Housekeeping	9.00	942,714	0	942,714	50,672.48	18.60	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	465,118	-322,544	142,574	7,382.07	19.31	34.00
35.00	Dietary under contract (see instructions)		66,970	0	66,970	2,120.00	31.59	35.00
36.00	Cafeteria	11.00	0	322,544	322,544	16,700.38	19.31	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	818,917	0	818,917	15,606.13	52.47	38.00
39.00	Central Services and Supply	14.00	294,588	0	294,588	12,157.45	24.23	39.00
40.00	Pharmacy	15.00	1,156,462	0	1,156,462	25,507.69	45.34	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part III Date/Time Prepared: 5/21/2024 9:54 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		32,553,835	0	32,553,835	863,241.41	37.71	1.00
2.00	Excluded area salaries (see instructions)		3,317,397	-119,606	3,197,791	82,015.47	38.99	2.00
3.00	Subtotal salaries (line 1 minus line 2)		29,236,438	119,606	29,356,044	781,225.94	37.58	3.00
4.00	Subtotal other wages & related costs (see inst.)		7,910,167	0	7,910,167	107,489.60	73.59	4.00
5.00	Subtotal wage-related costs (see inst.)		15,453,543	0	15,453,543	0.00	52.64	5.00
6.00	Total (sum of lines 3 thru 5)		52,600,148	119,606	52,719,754	888,715.54	59.32	6.00
7.00	Total overhead cost (see instructions)		8,604,641	0	8,604,641	255,514.16	33.68	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part IV Date/Time Prepared: 5/21/2024 9:54 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)	773,893	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	997,392	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)	9,177,822	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	469,716	9.00
10.00	Dental, Hearing and Vision Plan	658,542	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	31,848	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	5,780	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	66,289	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	417,735	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	2,475,939	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	154,861	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	4,883	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	15,234,700	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part V | Date/Time Prepared: 5/21/2024 9:54 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	3,144,896	15,234,700	1.00
2.00	Hospital	3,144,896	13,778,389	2.00
3.00	SUBPROVIDER - IPF	0	1,362,986	3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.30	Hospital-Based-CMHC 30	0	0	16.30
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	93,325	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0034	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/21/2024 9:54 am

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.233676	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	13,456,860	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	104,826,828	6.00
7.00	Medicaid cost (line 1 times line 6)	24,495,514	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	11,038,654	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	11,038,654	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	4,185,906	479,736	4,665,642	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	978,146	479,736	1,457,882	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,022,730	479,736	1,502,466	22.00
23.00	Cost of charity care (see instructions)	0	0	0	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	3,408,661	26.00
27.00	Medicare reimbursable bad debts (see instructions)	572,881	27.00
27.01	Medicare allowable bad debts (see instructions)	881,354	27.01
28.00	Non-Medicare bad debt amount (see instructions)	2,527,307	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	899,044	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	899,044	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	11,937,698	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0034	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/21/2024 9:54 am

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.217898	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		5.00
6.00	Medicaid charges		6.00
7.00	Medicaid cost (line 1 times line 6)		7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP		9.00
10.00	Stand-alone CHIP charges		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	3,889,747	465,389	4,355,136	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	847,568	465,389	1,312,957	21.00
22.00	Payments received from patients for amounts previously written off as charity care	946,494	465,389	1,411,883	22.00
23.00	Cost of charity care (see instructions)	0	0	0	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	3,208,247	26.00
27.00	Medicare reimbursable bad debts (see instructions)	545,732	27.00
27.01	Medicare allowable bad debts (see instructions)	839,587	27.01
28.00	Non-Medicare bad debt amount (see instructions)	2,368,660	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	809,981	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	809,981	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	809,981	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/21/2024 9:54 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,455,300	1,455,300	0	1,455,300	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,404,490	2,404,490	0	2,404,490	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	180,008	13,156,311	13,336,319	-295	13,336,024	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,300,906	21,335,651	24,636,557	-35,578	24,600,979	5.00
7.00	00700	OPERATION OF PLANT	834,133	3,576,417	4,410,550	61,106	4,471,656	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	91,574	313,848	405,422	-774	404,648	8.00
9.00	00900	HOUSEKEEPING	942,714	341,007	1,283,721	-23,445	1,260,276	9.00
10.00	01000	DIETARY	465,118	779,011	1,244,129	-862,949	381,180	10.00
11.00	01100	CAFETERIA	0	0	0	862,762	862,762	11.00
13.00	01300	NURSING ADMINISTRATION	818,917	905,268	1,724,185	-353	1,723,832	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	294,588	105,261	399,849	-130,913	268,936	14.00
15.00	01500	PHARMACY	1,156,462	4,254,888	5,411,350	-4,019,833	1,391,517	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	657	657	0	657	16.00
17.00	01700	SOCIAL SERVICE	0	10,263	10,263	-54	10,209	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,320,895	2,644,926	7,965,821	90,581	8,056,402	30.00
31.00	03100	INTENSIVE CARE UNIT	1,403,387	516,332	1,919,719	-496,569	1,423,150	31.00
40.00	04000	SUBPROVIDER - IPF	2,969,087	120,983	3,090,070	20,162	3,110,232	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,019,007	4,486,590	6,505,597	-3,480,666	3,024,931	50.00
51.00	05100	RECOVERY ROOM	938,139	138,849	1,076,988	-102,448	974,540	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	3,646,794	3,646,794	-93,735	3,553,059	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,133,523	119,736	1,253,259	-70,184	1,183,075	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	550,174	123,145	673,319	-2,241	671,078	55.00
56.00	05600	RADIOISOTOPE	106,212	344,396	450,608	-2,354	448,254	56.00
57.00	05700	CT SCAN	339,469	279,231	618,700	-55,132	563,568	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	171,719	43,358	215,077	-10,275	204,802	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,376,262	2,329,707	3,705,969	-1,042,386	2,663,583	60.00
64.00	06400	INTRAVENOUS THERAPY	270,439	35,249	305,688	-26,291	279,397	64.00
65.00	06500	RESPIRATORY THERAPY	1,151,014	523,955	1,674,969	-96,571	1,578,398	65.00
66.00	06600	PHYSICAL THERAPY	1,404,876	163,823	1,568,699	82,185	1,650,884	66.00
66.01	03340	CLINICAL NUTRITION	122,264	476	122,740	0	122,740	66.01
67.00	06700	OCCUPATIONAL THERAPY	159,747	1,801	161,548	10,977	172,525	67.00
68.00	06800	SPEECH PATHOLOGY	125,091	778	125,869	8,117	133,986	68.00
69.00	06900	ELECTROCARDIOLOGY	906,338	398,750	1,305,088	-66,069	1,239,019	69.00
69.01	03140	CARDIAC REHABILITATION	112,349	2,169	114,518	-130	114,388	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	63,639	139,086	202,725	-8,102	194,623	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,421,575	4,421,575	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,675,798	1,675,798	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,992,997	3,992,997	73.00
74.00	07400	RENAL DIALYSIS	0	111	111	-104	7	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,065,960	1,299,377	3,365,337	-105,905	3,259,432	90.00
91.00	09100	EMERGENCY	2,044,484	2,178,289	4,222,773	-348,530	3,874,243	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.30	09930	OOT	119,606	0	119,606	-128,438	-8,832	99.30
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,958,101	68,176,283	101,134,384	15,936	101,150,320	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,770	994	7,764	0	7,764	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	164,619	-5,118	159,501	0	159,501	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	57,315	237,062	294,377	-15,936	278,441	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	25,664	25,664	0	25,664	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	33,186,805	68,434,885	101,621,690	0	101,621,690	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/21/2024 9:54 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	856,948	2,312,248		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	490,229	2,894,719		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,725,162	18,061,186		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-10,324,152	14,276,827		5.00
7.00	00700	OPERATION OF PLANT	-80,101	4,391,555		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	404,648		8.00
9.00	00900	HOUSEKEEPING	-46,535	1,213,741		9.00
10.00	01000	DIETARY	0	381,180		10.00
11.00	01100	CAFETERIA	-258,444	604,318		11.00
13.00	01300	NURSING ADMINISTRATION	-217,555	1,506,277		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-45,661	223,275		14.00
15.00	01500	PHARMACY	-19,775	1,371,742		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,797	-1,140		16.00
17.00	01700	SOCIAL SERVICE	0	10,209		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,840,916	6,215,486		30.00
31.00	03100	INTENSIVE CARE UNIT	7,719	1,430,869		31.00
40.00	04000	SUBPROVIDER - IPF	-62,969	3,047,263		40.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-185,648	2,839,283		50.00
51.00	05100	RECOVERY ROOM	0	974,540		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	-3,457,683	95,376		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,646	1,179,429		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-19,720	651,358		55.00
56.00	05600	RADIOISOTOPE	0	448,254		56.00
57.00	05700	CT SCAN	-3	563,565		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	204,802		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	-217,205	2,446,378		60.00
64.00	06400	INTRAVENOUS THERAPY	-1	279,396		64.00
65.00	06500	RESPIRATORY THERAPY	-30,233	1,548,165		65.00
66.00	06600	PHYSICAL THERAPY	-86,385	1,564,499		66.00
66.01	03340	CLINICAL NUTRITION	0	122,740		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	172,525		67.00
68.00	06800	SPEECH PATHOLOGY	0	133,986		68.00
69.00	06900	ELECTROCARDIOLOGY	-231,832	1,007,187		69.00
69.01	03140	CARDIAC REHABILITATION	0	114,388		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-120,879	73,744		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-527,543	3,894,032		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,675,798		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,992,997		73.00
74.00	07400	RENAL DIALYSIS	0	7		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-742,467	2,516,965		90.00
91.00	09100	EMERGENCY	-753,684	3,120,559		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.30	09930	OOT	0	-8,832		99.30
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,194,776	87,955,544		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,764		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	159,501		192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0		192.01
194.00	07950	NON-REIMBURSABLE	0	278,441		194.00
194.01	07951	NON-REIMBURSABLE	0	0		194.01
194.02	07952	NON-REIMBURSABLE	0	0		194.02
194.03	07953	CONTRACT PHARMACY	0	25,664		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,194,776	88,426,914		200.00

RECLASSIFICATIONS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/21/2024 9:54 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DRUG, SUPPLY, IMPLANT, IV, AND BLOOD				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,421,575	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,675,798	2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,992,997	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
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
	0		0	10,090,370	
	B - DIETARY				
1.00	CAFETERIA	11.00	322,544	540,218	1.00
	0		322,544	540,218	
	C - IMPATIENT L&D				
1.00	ADULTS & PEDIATRICS	30.00	254,087	123,373	1.00
	0		254,087	123,373	
	E - UTILITIES				
1.00	OPERATION OF PLANT	7.00	0	61,430	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
	0		0	61,430	
	F - PUMP RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	0	72,427	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	8,459	2.00
3.00	SUBPROVIDER - IPF	40.00	0	49,661	3.00
	0		0	130,547	
	H - REHAB ADMIN				
1.00	PHYSICAL THERAPY	66.00	102,467	6,340	1.00
2.00	OCCUPATIONAL THERAPY	67.00	9,249	2,265	2.00
3.00	SPEECH PATHOLOGY	68.00	7,890	227	3.00
	0		119,606	8,832	
500.00	Grand Total: Increases		696,237	10,954,770	500.00

RECLASSIFICATIONS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/21/2024 9:54 am

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - DRUG, SUPPLY, IMPLANT, IV, AND BLOOD					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	295	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	8,195	0	2.00
3.00	OPERATION OF PLANT	7.00	0	324	0	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	774	0	4.00
5.00	HOUSEKEEPING	9.00	0	22,475	0	5.00
6.00	DIETARY	10.00	0	187	0	6.00
7.00	NURSING ADMINISTRATION	13.00	0	353	0	7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	366	0	8.00
9.00	PHARMACY	15.00	0	4,019,833	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	0	359,266	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	0	127,568	0	11.00
12.00	SUBPROVIDER - IPF	40.00	0	29,499	0	12.00
13.00	OPERATING ROOM	50.00	0	3,480,666	0	13.00
14.00	RECOVERY ROOM	51.00	0	102,448	0	14.00
15.00	ANESTHESIOLOGY	53.00	0	93,735	0	15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	70,184	0	16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00	0	2,241	0	17.00
18.00	RADIOISOTOPE	56.00	0	2,354	0	18.00
19.00	CT SCAN	57.00	0	55,132	0	19.00
20.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	10,275	0	20.00
21.00	LABORATORY	60.00	0	1,042,386	0	21.00
22.00	INTRAVENOUS THERAPY	64.00	0	26,291	0	22.00
23.00	RESPIRATORY THERAPY	65.00	0	96,571	0	23.00
24.00	PHYSICAL THERAPY	66.00	0	9,575	0	24.00
25.00	OCCUPATIONAL THERAPY	67.00	0	537	0	25.00
26.00	ELECTROCARDIOLOGY	69.00	0	66,069	0	26.00
27.00	CARDIAC REHABILITATION	69.01	0	130	0	27.00
28.00	ELECTROENCEPHALOGRAPHY	70.00	0	8,102	0	28.00
29.00	RENAL DIALYSIS	74.00	0	104	0	29.00
30.00	CLINIC	90.00	0	105,905	0	30.00
31.00	EMERGENCY	91.00	0	348,530	0	31.00
	0		0	10,090,370		
	B - DIETARY					
1.00	DIETARY	10.00	322,544	540,218	0	1.00
	0		322,544	540,218		
	C - IMPATIENT L&D					
1.00	INTENSIVE CARE UNIT	31.00	254,087	123,373	0	1.00
	0		254,087	123,373		
	E - UTILITIES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	27,383	0	1.00
2.00	HOUSEKEEPING	9.00	0	970	0	2.00
3.00	SOCIAL SERVICE	17.00	0	54	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	40	0	4.00
5.00	PHYSICAL THERAPY	66.00	0	17,047	0	5.00
6.00	NON-REIMBURSABLE	194.00	0	15,936	0	6.00
	0		0	61,430		
	F - PUMP RECLASS					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	130,547	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	0		0	130,547		
	H - REHAB ADMIN					
1.00	OOT	99.30	119,606	8,832	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	0		119,606	8,832		
500.00	Grand Total: Decreases		696,237	10,954,770		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/21/2024 9:54 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	1,301,090	1,060	0	1,060	0	1.00
2.00	Land Improvements	714,463	72,847	0	72,847	0	2.00
3.00	Buildings and Fixtures	47,128,193	209,521	-43,796	165,725	0	3.00
4.00	Building Improvements	648,846	131,903	-592,636	-460,733	0	4.00
5.00	Fixed Equipment	5,561,439	658,319	0	658,319	703,650	5.00
6.00	Movable Equipment	34,369,271	2,209,288	636,432	2,845,720	109,221	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	89,723,302	3,282,938	0	3,282,938	812,871	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	89,723,302	3,282,938	0	3,282,938	812,871	10.00

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,302,150	0				1.00
2.00	Land Improvements	787,310	0				2.00
3.00	Buildings and Fixtures	47,293,918	0				3.00
4.00	Building Improvements	188,113	0				4.00
5.00	Fixed Equipment	5,516,108	0				5.00
6.00	Movable Equipment	37,105,770	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	92,193,369	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	92,193,369	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/21/2024 9:54 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	1,726,703	0	-271,403	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,404,490	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,131,193	0	-271,403	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	1,455,300		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,404,490		2.00
3.00	Total (sum of lines 1-2)	0	3,859,790		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III Date/Time Prepared: 5/21/2024 9:54 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	49,571,490	0	49,571,490	0.537690	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	42,621,877	0	42,621,877	0.462310	0	2.00
3.00	Total (sum of lines 1-2)	92,193,367	0	92,193,367	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	1,975,332	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,894,719	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,870,051	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	336,916	0	0	0	2,312,248	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,894,719	2.00
3.00	Total (sum of lines 1-2)	336,916	0	0	0	5,206,967	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/21/2024 9:54 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		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)	A	0	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-8,098,036			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	-1,975,996			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-258,444	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	B	-19,371	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,797	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	145,548	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	106,628	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS REVENUE	B	-2,709,325	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/21/2024 9:54 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISCELLANEOUS REVENUE	B	-10,989	OPERATION OF PLANT	7.00	0	33.01
33.02	MISCELLANEOUS REVENUE	B	-46,535	HOUSEKEEPING	9.00	0	33.02
33.03	MISCELLANEOUS REVENUE	B	-5	NURSING ADMINISTRATION	13.00	0	33.03
33.04	MISCELLANEOUS REVENUE	B	5	CENTRAL SERVICES & SUPPLY	14.00	0	33.04
33.05	MISCELLANEOUS REVENUE	B	-1,056	INTENSIVE CARE UNIT	31.00	0	33.05
33.06	MISCELLANEOUS REVENUE	B	1	SUBPROVIDER - IPF	40.00	0	33.06
33.07	MISCELLANEOUS REVENUE	B	-31,280	OPERATING ROOM	50.00	0	33.07
33.08	MISCELLANEOUS REVENUE	B	-3,539	RADIOLOGY-DIAGNOSTIC	54.00	0	33.08
33.09	MISCELLANEOUS REVENUE	B	-2	RADIOLOGY-THERAPEUTIC	55.00	0	33.09
33.10	MISCELLANEOUS REVENUE	B	-3	CT SCAN	57.00	0	33.10
33.11	MISCELLANEOUS REVENUE	B	-3	LABORATORY	60.00	0	33.11
33.12	MISCELLANEOUS REVENUE	B	-1	INTRAVENOUS THERAPY	64.00	0	33.12
33.13	MISCELLANEOUS REVENUE	B	-10,128	RESPIRATORY THERAPY	65.00	0	33.13
33.14	MISCELLANEOUS REVENUE	B	-6,422	PHYSICAL THERAPY	66.00	0	33.14
33.15	MISCELLANEOUS REVENUE	B	-151	ELECTROCARDIOLOGY	69.00	0	33.15
33.16	MISCELLANEOUS REVENUE	B	-1	ELECTROENCEPHALOGRAPHY	70.00	0	33.16
33.17	MISCELLANEOUS REVENUE	B	-6,107	CLINIC	90.00	0	33.17
33.18	MARKETING	A	-1,948	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	MARKETING	A	-544	NURSING ADMINISTRATION	13.00	0	33.19
33.20	MARKETING	A	-107	RADIOLOGY-DIAGNOSTIC	54.00	0	33.20
33.21	MARKETING	A	-773	RADIOLOGY-THERAPEUTIC	55.00	0	33.21
33.22	MARKETING	A	-722	RESPIRATORY THERAPY	65.00	0	33.22
33.23	MARKETING	A	-1,755	CLINIC	90.00	0	33.23
33.24	RECRUITMENT	A	-215,922	NURSING ADMINISTRATION	13.00	0	33.24
33.25	GIFT	B	-28,188	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	GIFT	B	-1,084	NURSING ADMINISTRATION	13.00	0	33.26
33.27	GIFT	B	-404	PHARMACY	15.00	0	33.27
33.28	GIFT	B	-50	ADULTS & PEDIATRICS	30.00	0	33.28
34.00	GIFT	B	-211	RADIOLOGY-THERAPEUTIC	55.00	0	34.00
34.01	GIFT	B	-74	PHYSICAL THERAPY	66.00	0	34.01
34.02	GIFT	B	-468	CLINIC	90.00	0	34.02
34.03	ENTERTAINMENT	B	-1,384	ADMINISTRATIVE & GENERAL	5.00	0	34.03
34.04	INTEREST	A	337,167	CAP REL COSTS-BLDG & FIXT	1.00	11	34.04
34.05	WSI RENT	A	-79,889	PHYSICAL THERAPY	66.00	0	34.05
34.06	PHYSICAN PART B BENEFITS	A	-271,411	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.06
38.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	41.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,194,776				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: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/21/2024 9:54 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	103,081	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	470,822	87,221	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE - INTEREST	0	-271,152	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	5,011,116	14,543	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	10,214,563	17,302,645	4.01
4.02	7.00	OPERATION OF PLANT	HOME OFFICE	0	69,112	4.02
4.03	14.00	CENTRAL SERVICES & SUPPLY	HOME OFFICE	0	45,666	4.03
4.04	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	-527,543	0	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			15,272,039	17,248,035	5.00

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

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

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

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

6.00	G	SSM HEALTH	100.00	FRAN SISTERS	100.00	6.00
7.00	G	SSM HEALTH	100.00	FRAN SISTERS	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	CHURCH				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: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/21/2024 9:54 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	103,081	9		1.00
2.00	383,601	9		2.00
3.00	271,152	11		3.00
4.00	4,996,573	0		4.00
4.01	-7,088,082	0		4.01
4.02	-69,112	0		4.02
4.03	-45,666	0		4.03
4.04	-527,543	0		4.04
5.00	-1,975,996			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	SSM HOSPITALS		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/21/2024 9:54 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	602,195	457,019	145,176	211,500	1,052	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,840,866	1,840,866	0	197,500	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	-8,775	-8,775	0	211,500	0	3.00
4.00	40.00	SUBPROVIDER - IPF	62,970	62,970	0	181,300	0	4.00
5.00	50.00	OPERATING ROOM	178,060	133,339	44,720	246,400	200	5.00
6.00	53.00	ANESTHESIOLOGY	3,457,683	3,457,683	0	239,400	0	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	18,734	18,734	0	271,900	0	7.00
8.00	60.00	LABORATORY	217,202	217,202	0	260,300	0	8.00
9.00	65.00	RESPIRATORY THERAPY	24,162	14,812	9,350	211,500	47	9.00
10.00	69.00	ELECTROCARDIOLOGY	245,205	221,205	24,000	211,500	133	10.00
11.00	70.00	ELECTROENCEPHALOGRAPHY	125,657	116,307	9,350	211,500	47	11.00
12.00	90.00	CLINIC	734,137	734,137	0	197,500	0	12.00
13.00	91.00	EMERGENCY	779,321	725,421	53,900	197,500	270	13.00
200.00			8,277,417	7,990,920	286,496		1,749	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	106,970	5,349	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	23,692	1,185	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	0	0	0	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	4,779	239	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	13,524	676	0	0	0	10.00
11.00	70.00	ELECTROENCEPHALOGRAPHY	4,779	239	0	0	0	11.00
12.00	90.00	CLINIC	0	0	0	0	0	12.00
13.00	91.00	EMERGENCY	25,637	1,282	0	0	0	13.00
200.00			179,381	8,970	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	106,970	38,206	495,225		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,840,866		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	-8,775		3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	62,970		4.00
5.00	50.00	OPERATING ROOM	0	23,692	21,028	154,368		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	3,457,683		6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	18,734		7.00
8.00	60.00	LABORATORY	0	0	0	217,202		8.00
9.00	65.00	RESPIRATORY THERAPY	0	4,779	4,571	19,383		9.00
10.00	69.00	ELECTROCARDIOLOGY	0	13,524	10,476	231,681		10.00
11.00	70.00	ELECTROENCEPHALOGRAPHY	0	4,779	4,571	120,878		11.00
12.00	90.00	CLINIC	0	0	0	734,137		12.00
13.00	91.00	EMERGENCY	0	25,637	28,263	753,684		13.00
200.00			0	179,381	107,115	8,098,036		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/21/2024 9:54 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,312,248	2,312,248				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,894,719		2,894,719			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	18,061,186	12,612	15,789	18,089,587		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,276,827	697,907	873,716	1,809,081	17,657,531	5.00
7.00	00700	OPERATION OF PLANT	4,391,555	174,676	218,678	457,152	5,242,061	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	404,648	47,970	60,053	50,188	562,859	8.00
9.00	00900	HOUSEKEEPING	1,213,741	30,466	38,140	516,660	1,799,007	9.00
10.00	01000	DIETARY	381,180	17,094	21,400	78,139	497,813	10.00
11.00	01100	CAFETERIA	604,318	43,827	54,867	176,772	879,784	11.00
13.00	01300	NURSING ADMINISTRATION	1,506,277	4,310	5,396	448,812	1,964,795	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	223,275	2,828	3,541	161,451	391,095	14.00
15.00	01500	PHARMACY	1,371,742	0	0	633,806	2,005,548	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,140	26,048	32,610	0	57,518	16.00
17.00	01700	SOCIAL SERVICE	10,209	10,829	13,557	0	34,595	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,215,486	351,405	439,927	3,055,414	10,062,232	30.00
31.00	03100	INTENSIVE CARE UNIT	1,430,869	31,242	39,112	629,881	2,131,104	31.00
40.00	04000	SUBPROVIDER - IPF	3,047,263	38,595	48,318	1,627,226	4,761,402	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,839,283	246,200	308,219	1,106,529	4,500,231	50.00
51.00	05100	RECOVERY ROOM	974,540	0	0	514,153	1,488,693	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	95,376	2,241	2,806	0	100,423	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,179,429	69,417	86,903	621,234	1,956,983	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	651,358	0	0	301,526	952,884	55.00
56.00	05600	RADIOISOTOPE	448,254	18,511	23,174	58,210	548,149	56.00
57.00	05700	CT SCAN	563,565	1,261	1,578	186,048	752,452	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	204,802	2,198	2,752	94,112	303,864	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,446,378	32,028	40,096	754,269	3,272,771	60.00
64.00	06400	INTRAVENOUS THERAPY	279,396	5,716	7,156	148,216	440,484	64.00
65.00	06500	RESPIRATORY THERAPY	1,548,165	6,740	8,437	630,820	2,194,162	65.00
66.00	06600	PHYSICAL THERAPY	1,564,499	25,650	32,111	826,108	2,448,368	66.00
66.01	03340	CLINICAL NUTRITION	122,740	0	0	67,008	189,748	66.01
67.00	06700	OCCUPATIONAL THERAPY	172,525	0	0	92,619	265,144	67.00
68.00	06800	SPEECH PATHOLOGY	133,986	3,895	4,876	72,881	215,638	68.00
69.00	06900	ELECTROCARDIOLOGY	1,007,187	32,319	40,461	496,724	1,576,691	69.00
69.01	03140	CARDIAC REHABILITATION	114,388	0	0	61,574	175,962	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	73,744	11,879	14,872	34,878	135,373	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,894,032	0	0	0	3,894,032	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,675,798	0	0	0	1,675,798	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,992,997	0	0	0	3,992,997	73.00
74.00	07400	RENAL DIALYSIS	7	0	0	0	7	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,516,965	59,472	74,453	1,132,262	3,783,152	90.00
91.00	09100	EMERGENCY	3,120,559	58,470	73,199	1,120,492	4,372,720	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.30	09930	OOT	-8,832	0	0	0	-8,832	99.30
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	87,955,544	2,065,806	2,586,197	17,964,245	87,275,238	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,764	1,767	2,212	3,710	15,453	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	159,501	0	0	90,220	249,721	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	278,441	244,675	306,310	31,412	860,838	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	25,664	0	0	0	25,664	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	88,426,914	2,312,248	2,894,719	18,089,587	88,426,914	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/21/2024 9:54 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,657,531					5.00
7.00	00700	OPERATION OF PLANT	1,307,774	6,549,835				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	140,420	220,169	923,448			8.00
9.00	00900	HOUSEKEEPING	448,811	139,831	0	2,387,649		9.00
10.00	01000	DIETARY	124,193	78,459	0	30,264	730,729	10.00
11.00	01100	CAFETERIA	219,486	201,154	0	77,593	0	11.00
13.00	01300	NURSING ADMINISTRATION	490,171	19,782	0	7,630	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	97,569	12,982	0	5,008	0	14.00
15.00	01500	PHARMACY	500,338	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,349	119,555	0	46,117	0	16.00
17.00	01700	SOCIAL SERVICE	8,631	49,701	0	19,172	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,510,291	1,612,870	512,342	622,141	405,419	30.00
31.00	03100	INTENSIVE CARE UNIT	531,661	143,392	60,049	55,312	47,517	31.00
40.00	04000	SUBPROVIDER - IPF	1,187,860	177,144	351,057	68,331	277,793	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,122,704	1,129,999	0	435,883	0	50.00
51.00	05100	RECOVERY ROOM	371,395	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	25,053	10,286	0	3,968	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	488,222	318,607	0	122,899	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	237,723	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	136,751	84,962	0	32,773	0	56.00
57.00	05700	CT SCAN	187,719	5,786	0	2,232	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	75,807	10,089	0	3,892	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	816,481	147,002	0	56,704	0	60.00
64.00	06400	INTRAVENOUS THERAPY	109,891	26,235	0	10,120	0	64.00
65.00	06500	RESPIRATORY THERAPY	547,393	30,933	0	11,932	0	65.00
66.00	06600	PHYSICAL THERAPY	610,812	117,725	0	45,411	0	66.00
66.01	03340	CLINICAL NUTRITION	47,338	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	66,147	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	53,797	17,878	0	6,896	0	68.00
69.00	06900	ELECTROCARDIOLOGY	393,348	148,337	0	57,219	0	69.00
69.01	03140	CARDIAC REHABILITATION	43,898	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	33,772	54,523	0	21,032	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	971,471	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	418,073	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	996,161	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	943,809	272,961	0	105,291	0	90.00
91.00	09100	EMERGENCY	1,090,893	268,362	0	103,517	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.30	09930	OOT	0	0	0	0	0	99.30
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,370,214	5,418,724	923,448	1,951,337	730,729	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,855	8,110	0	3,129	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	62,300	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	214,759	1,123,001	0	433,183	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	6,403	0	0	0	0	194.03
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)	17,657,531	6,549,835	923,448	2,387,649	730,729	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/21/2024 9:54 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,378,017					11.00
13.00	01300	NURSING ADMINISTRATION	41,227	2,523,605				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,830	0	521,484			14.00
15.00	01500	PHARMACY	58,220	0	0	2,564,106		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	237,539	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	280,672	737,291	55,092	120,393	12,430	30.00
31.00	03100	INTENSIVE CARE UNIT	57,859	185,234	21,327	33,945	1,711	31.00
40.00	04000	SUBPROVIDER - IPF	149,473	360,254	4,085	4,679	4,842	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	101,643	288,848	212,047	342,274	29,341	50.00
51.00	05100	RECOVERY ROOM	47,229	197,708	1,157	10,268	7,714	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	9,337	778,564	9,054	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,065	15,863	8,960	40,947	10,637	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	27,697	19,850	1,440	0	4,688	55.00
56.00	05600	RADIOISOTOPE	5,347	434	248	152,862	4,742	56.00
57.00	05700	CT SCAN	17,090	1,120	6,495	628,780	36,418	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,645	2,375	666	9,515	6,356	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	69,285	0	140,928	1,915	31,055	60.00
64.00	06400	INTRAVENOUS THERAPY	13,615	54,114	2,827	18,527	1,199	64.00
65.00	06500	RESPIRATORY THERAPY	57,945	0	9,456	659	6,951	65.00
66.00	06600	PHYSICAL THERAPY	75,884	0	972	785	6,069	66.00
66.01	03340	CLINICAL NUTRITION	6,155	0	0	0	19	66.01
67.00	06700	OCCUPATIONAL THERAPY	8,508	0	23	0	865	67.00
68.00	06800	SPEECH PATHOLOGY	6,695	0	0	0	407	68.00
69.00	06900	ELECTROCARDIOLOGY	45,628	55,611	2,967	6,940	9,343	69.00
69.01	03140	CARDIAC REHABILITATION	5,656	27,525	93	4,773	412	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	3,204	0	385	21,259	1,548	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,069	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,093	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	14,413	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	104,007	262,366	3,438	329,839	6,552	90.00
91.00	09100	EMERGENCY	102,925	295,114	39,541	57,182	25,611	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.30	09930	OOT	0	0	0	0	0	99.30
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,366,504	2,503,707	521,484	2,564,106	237,539	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	341	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,287	19,898	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	2,885	0	0	0	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	0	0	0	194.03
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)	1,378,017	2,523,605	521,484	2,564,106	237,539	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/21/2024 9:54 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	112,099					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	62,195	16,993,368	0	16,993,368		30.00
31.00	03100	INTENSIVE CARE UNIT	7,289	3,276,400	0	3,276,400		31.00
40.00	04000	SUBPROVIDER - IPF	42,615	7,389,535	0	7,389,535		40.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	8,162,970	0	8,162,970		50.00
51.00	05100	RECOVERY ROOM	0	2,124,164	0	2,124,164		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	936,685	0	936,685		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,020,183	0	3,020,183		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,244,282	0	1,244,282		55.00
56.00	05600	RADIOISOTOPE	0	966,268	0	966,268		56.00
57.00	05700	CT SCAN	0	1,638,092	0	1,638,092		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	421,209	0	421,209		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	4,536,141	0	4,536,141		60.00
64.00	06400	INTRAVENOUS THERAPY	0	677,012	0	677,012		64.00
65.00	06500	RESPIRATORY THERAPY	0	2,859,431	0	2,859,431		65.00
66.00	06600	PHYSICAL THERAPY	0	3,306,026	0	3,306,026		66.00
66.01	03340	CLINICAL NUTRITION	0	243,260	0	243,260		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	340,687	0	340,687		67.00
68.00	06800	SPEECH PATHOLOGY	0	301,311	0	301,311		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,296,084	0	2,296,084		69.00
69.01	03140	CARDIAC REHABILITATION	0	258,319	0	258,319		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	271,096	0	271,096		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,868,572	0	4,868,572		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,095,964	0	2,095,964		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,003,571	0	5,003,571		73.00
74.00	07400	RENAL DIALYSIS	0	9	0	9		74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,811,415	0	5,811,415		90.00
91.00	09100	EMERGENCY	0	6,355,865	0	6,355,865		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
99.30	09930	OOT	0	-8,832	0	-8,832		99.30
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	112,099	85,389,087	0	85,389,087		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30,888	0	30,888		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	340,206	0	340,206		192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.01
194.00	07950	NON-REIMBURSABLE	0	2,634,666	0	2,634,666		194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0		194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0		194.02
194.03	07953	CONTRACT PHARMACY	0	32,067	0	32,067		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	112,099	88,426,914	0	88,426,914		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/21/2024 9:54 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,612	15,789	28,401	28,401	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	49,668	697,907	873,716	1,621,291	2,839	5.00
7.00	00700	OPERATION OF PLANT	669	174,676	218,678	394,023	717	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	47,970	60,053	108,023	79	8.00
9.00	00900	HOUSEKEEPING	0	30,466	38,140	68,606	811	9.00
10.00	01000	DIETARY	0	17,094	21,400	38,494	123	10.00
11.00	01100	CAFETERIA	0	43,827	54,867	98,694	277	11.00
13.00	01300	NURSING ADMINISTRATION	14,642	4,310	5,396	24,348	704	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,094	2,828	3,541	8,463	253	14.00
15.00	01500	PHARMACY	130,548	0	0	130,548	995	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,048	32,610	58,658	0	16.00
17.00	01700	SOCIAL SERVICE	0	10,829	13,557	24,386	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,444	351,405	439,927	795,776	4,810	30.00
31.00	03100	INTENSIVE CARE UNIT	1,004	31,242	39,112	71,358	988	31.00
40.00	04000	SUBPROVIDER - IPF	0	38,595	48,318	86,913	2,553	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	86,790	246,200	308,219	641,209	1,736	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	807	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,241	2,806	5,047	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	69,417	86,903	156,320	975	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	473	55.00
56.00	05600	RADIOISOTOPE	0	18,511	23,174	41,685	91	56.00
57.00	05700	CT SCAN	0	1,261	1,578	2,839	292	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,198	2,752	4,950	148	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	32,028	40,096	72,124	1,184	60.00
64.00	06400	INTRAVENOUS THERAPY	0	5,716	7,156	12,872	233	64.00
65.00	06500	RESPIRATORY THERAPY	114,231	6,740	8,437	129,408	990	65.00
66.00	06600	PHYSICAL THERAPY	80,120	25,650	32,111	137,881	1,296	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	0	105	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	145	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,895	4,876	8,771	114	68.00
69.00	06900	ELECTROCARDIOLOGY	0	32,319	40,461	72,780	779	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	0	97	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11,879	14,872	26,751	55	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	62,476	59,472	74,453	196,401	1,777	90.00
91.00	09100	EMERGENCY	0	58,470	73,199	131,669	1,758	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.30	09930	OOT	0	0	0	0	0	99.30
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	546,686	2,065,806	2,586,197	5,198,689	28,204	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,767	2,212	3,979	6	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	127	0	0	127	142	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	18,180	244,675	306,310	569,165	49	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	564,993	2,312,248	2,894,719	5,771,960	28,401	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/21/2024 9:54 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,624,130					5.00
7.00	00700	OPERATION OF PLANT	120,290	515,030				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,916	17,312	138,330			8.00
9.00	00900	HOUSEKEEPING	41,282	10,995	0	121,694		9.00
10.00	01000	DIETARY	11,423	6,169	0	1,543	57,752	10.00
11.00	01100	CAFETERIA	20,188	15,817	0	3,955	0	11.00
13.00	01300	NURSING ADMINISTRATION	45,086	1,555	0	389	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,974	1,021	0	255	0	14.00
15.00	01500	PHARMACY	46,021	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,320	9,401	0	2,350	0	16.00
17.00	01700	SOCIAL SERVICE	794	3,908	0	977	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	230,882	126,826	76,748	31,711	32,042	30.00
31.00	03100	INTENSIVE CARE UNIT	48,902	11,275	8,995	2,819	3,755	31.00
40.00	04000	SUBPROVIDER - IPF	109,260	13,929	52,587	3,483	21,955	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	103,267	88,855	0	22,216	0	50.00
51.00	05100	RECOVERY ROOM	34,161	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,304	809	0	202	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,907	25,053	0	6,264	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	21,866	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	12,578	6,681	0	1,670	0	56.00
57.00	05700	CT SCAN	17,267	455	0	114	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,973	793	0	198	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	75,100	11,559	0	2,890	0	60.00
64.00	06400	INTRAVENOUS THERAPY	10,108	2,063	0	516	0	64.00
65.00	06500	RESPIRATORY THERAPY	50,349	2,432	0	608	0	65.00
66.00	06600	PHYSICAL THERAPY	56,183	9,257	0	2,315	0	66.00
66.01	03340	CLINICAL NUTRITION	4,354	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	6,084	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,948	1,406	0	351	0	68.00
69.00	06900	ELECTROCARDIOLOGY	36,180	11,664	0	2,916	0	69.00
69.01	03140	CARDIAC REHABILITATION	4,038	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	3,106	4,287	0	1,072	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	89,356	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,455	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	91,627	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	86,812	21,464	0	5,366	0	90.00
91.00	09100	EMERGENCY	100,341	21,102	0	5,276	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.30	09930	OOT	0	0	0	0	0	99.30
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,597,702	426,088	138,330	99,456	57,752	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	355	638	0	159	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,730	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	19,754	88,304	0	22,079	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	589	0	0	0	0	194.03
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)	1,624,130	515,030	138,330	121,694	57,752	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/21/2024 9:54 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	138,931					11.00
13.00	01300	NURSING ADMINISTRATION	4,157	76,239				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,495	0	20,461			14.00
15.00	01500	PHARMACY	5,870	0	0	183,434		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	71,386	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,286	22,273	2,162	8,613	3,729	30.00
31.00	03100	INTENSIVE CARE UNIT	5,834	5,596	837	2,428	513	31.00
40.00	04000	SUBPROVIDER - IPF	15,071	10,883	160	335	1,453	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,248	8,726	8,320	24,486	8,802	50.00
51.00	05100	RECOVERY ROOM	4,762	5,973	45	735	2,314	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	366	55,699	2,716	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,754	479	352	2,929	3,191	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,793	600	57	0	1,407	55.00
56.00	05600	RADIOISOTOPE	539	13	10	10,936	1,423	56.00
57.00	05700	CT SCAN	1,723	34	255	44,982	11,047	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	872	72	26	681	1,907	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	6,986	0	5,529	137	9,317	60.00
64.00	06400	INTRAVENOUS THERAPY	1,373	1,635	111	1,325	360	64.00
65.00	06500	RESPIRATORY THERAPY	5,843	0	371	47	2,085	65.00
66.00	06600	PHYSICAL THERAPY	7,651	0	38	56	1,821	66.00
66.01	03340	CLINICAL NUTRITION	621	0	0	0	6	66.01
67.00	06700	OCCUPATIONAL THERAPY	858	0	1	0	260	67.00
68.00	06800	SPEECH PATHOLOGY	675	0	0	0	122	68.00
69.00	06900	ELECTROCARDIOLOGY	4,601	1,680	116	496	2,803	69.00
69.01	03140	CARDIAC REHABILITATION	570	832	4	341	124	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	323	0	15	1,521	464	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	921	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	628	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,324	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,487	7,926	135	23,596	1,966	90.00
91.00	09100	EMERGENCY	10,378	8,916	1,551	4,091	7,683	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.30	09930	OOT	0	0	0	0	0	99.30
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	137,770	75,638	20,461	183,434	71,386	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	34	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	836	601	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	291	0	0	0	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	343	201.00
202.00		TOTAL (sum lines 118 through 201)	138,931	76,239	20,461	183,434	71,729	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/21/2024 9:54 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	30,065					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,681	1,380,539	0	1,380,539		30.00
31.00	03100	INTENSIVE CARE UNIT	1,955	165,255	0	165,255		31.00
40.00	04000	SUBPROVIDER - IPF	11,429	330,011	0	330,011		40.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	917,865	0	917,865		50.00
51.00	05100	RECOVERY ROOM	0	48,797	0	48,797		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	67,143	0	67,143		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	246,224	0	246,224		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	27,196	0	27,196		55.00
56.00	05600	RADIOISOTOPE	0	75,626	0	75,626		56.00
57.00	05700	CT SCAN	0	79,008	0	79,008		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	16,620	0	16,620		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	184,826	0	184,826		60.00
64.00	06400	INTRAVENOUS THERAPY	0	30,596	0	30,596		64.00
65.00	06500	RESPIRATORY THERAPY	0	192,133	0	192,133		65.00
66.00	06600	PHYSICAL THERAPY	0	216,498	0	216,498		66.00
66.01	03340	CLINICAL NUTRITION	0	5,086	0	5,086		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	7,348	0	7,348		67.00
68.00	06800	SPEECH PATHOLOGY	0	16,387	0	16,387		68.00
69.00	06900	ELECTROCARDIOLOGY	0	134,015	0	134,015		69.00
69.01	03140	CARDIAC REHABILITATION	0	6,006	0	6,006		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	37,594	0	37,594		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	90,277	0	90,277		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	39,083	0	39,083		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	95,951	0	95,951		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	355,930	0	355,930		90.00
91.00	09100	EMERGENCY	0	292,765	0	292,765		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
99.30	09930	OOT	0	0	0	0		99.30
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,065	5,058,779	0	5,058,779		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,171	0	5,171		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,436	0	7,436		192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.01
194.00	07950	NON-REIMBURSABLE	0	699,642	0	699,642		194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0		194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0		194.02
194.03	07953	CONTRACT PHARMACY	0	589	0	589		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	343	0	343		201.00
202.00		TOTAL (sum lines 118 through 201)	30,065	5,771,960	0	5,771,960		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/21/2024 9:54 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	429,194					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		429,194				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,341	2,341	33,006,797			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	129,544	129,544	3,300,906	-17,657,531	70,778,215	5.00
7.00	00700	OPERATION OF PLANT	32,423	32,423	834,133	0	5,242,061	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,904	8,904	91,574	0	562,859	8.00
9.00	00900	HOUSEKEEPING	5,655	5,655	942,714	0	1,799,007	9.00
10.00	01000	DIETARY	3,173	3,173	142,574	0	497,813	10.00
11.00	01100	CAFETERIA	8,135	8,135	322,544	0	879,784	11.00
13.00	01300	NURSING ADMINISTRATION	800	800	818,917	0	1,964,795	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	525	525	294,588	0	391,095	14.00
15.00	01500	PHARMACY	0	0	1,156,462	0	2,005,548	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,835	4,835	0	0	57,518	16.00
17.00	01700	SOCIAL SERVICE	2,010	2,010	0	0	34,595	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,227	65,227	5,574,982	0	10,062,232	30.00
31.00	03100	INTENSIVE CARE UNIT	5,799	5,799	1,149,300	0	2,131,104	31.00
40.00	04000	SUBPROVIDER - IPF	7,164	7,164	2,969,087	0	4,761,402	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,699	45,699	2,019,007	0	4,500,231	50.00
51.00	05100	RECOVERY ROOM	0	0	938,139	0	1,488,693	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	416	416	0	0	100,423	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,885	12,885	1,133,523	0	1,956,983	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	550,174	0	952,884	55.00
56.00	05600	RADIOISOTOPE	3,436	3,436	106,212	0	548,149	56.00
57.00	05700	CT SCAN	234	234	339,469	0	752,452	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	408	408	171,719	0	303,864	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	5,945	5,945	1,376,262	0	3,272,771	60.00
64.00	06400	INTRAVENOUS THERAPY	1,061	1,061	270,439	0	440,484	64.00
65.00	06500	RESPIRATORY THERAPY	1,251	1,251	1,151,014	0	2,194,162	65.00
66.00	06600	PHYSICAL THERAPY	4,761	4,761	1,507,343	0	2,448,368	66.00
66.01	03340	CLINICAL NUTRITION	0	0	122,264	0	189,748	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	168,996	0	265,144	67.00
68.00	06800	SPEECH PATHOLOGY	723	723	132,981	0	215,638	68.00
69.00	06900	ELECTROCARDIOLOGY	5,999	5,999	906,338	0	1,576,691	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	112,349	0	175,962	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	2,205	2,205	63,639	0	135,373	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,894,032	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,675,798	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,992,997	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	7	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,039	11,039	2,065,960	0	3,783,152	90.00
91.00	09100	EMERGENCY	10,853	10,853	2,044,484	0	4,372,720	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.30	09930	OOT	0	0	0	8,832	0	99.30
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	383,450	383,450	32,778,093	-17,648,699	69,626,539	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	328	328	6,770	0	15,453	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	164,619	0	249,721	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	45,416	45,416	57,315	0	860,838	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	0	0	25,664	194.03
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)	2,312,248	2,894,719	18,089,587		17,657,531	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.387419	6.744547	0.548056		0.249477	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/21/2024 9:54 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
204.00		Cost to be allocated (per Wkst. B, Part II)			28,401		1,624,130	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000860		0.022947	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: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/21/2024 9:54 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	264,886					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,904	14,394				8.00
9.00	00900	HOUSEKEEPING	5,655	0	250,327			9.00
10.00	01000	DIETARY	3,173	0	3,173	14,394		10.00
11.00	01100	CAFETERIA	8,135	0	8,135	0	27,372,352	11.00
13.00	01300	NURSING ADMINISTRATION	800	0	800	0	818,917	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	525	0	525	0	294,588	14.00
15.00	01500	PHARMACY	0	0	0	0	1,156,462	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,835	0	4,835	0	0	16.00
17.00	01700	SOCIAL SERVICE	2,010	0	2,010	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,227	7,986	65,227	7,986	5,574,982	30.00
31.00	03100	INTENSIVE CARE UNIT	5,799	936	5,799	936	1,149,300	31.00
40.00	04000	SUBPROVIDER - IPF	7,164	5,472	7,164	5,472	2,969,087	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,699	0	45,699	0	2,019,007	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	938,139	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	416	0	416	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,885	0	12,885	0	1,133,523	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	550,174	55.00
56.00	05600	RADIOISOTOPE	3,436	0	3,436	0	106,212	56.00
57.00	05700	CT SCAN	234	0	234	0	339,469	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	408	0	408	0	171,719	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	5,945	0	5,945	0	1,376,262	60.00
64.00	06400	INTRAVENOUS THERAPY	1,061	0	1,061	0	270,439	64.00
65.00	06500	RESPIRATORY THERAPY	1,251	0	1,251	0	1,151,014	65.00
66.00	06600	PHYSICAL THERAPY	4,761	0	4,761	0	1,507,343	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	0	122,264	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	168,996	67.00
68.00	06800	SPEECH PATHOLOGY	723	0	723	0	132,981	68.00
69.00	06900	ELECTROCARDIOLOGY	5,999	0	5,999	0	906,338	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	0	112,349	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	2,205	0	2,205	0	63,639	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,039	0	11,039	0	2,065,960	90.00
91.00	09100	EMERGENCY	10,853	0	10,853	0	2,044,484	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.30	09930	OOT	0	0	0	0	0	99.30
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	219,142	14,394	204,583	14,394	27,143,648	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	328	0	328	0	6,770	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	164,619	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	45,416	0	45,416	0	57,315	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,549,835	923,448	2,387,649	730,729	1,378,017	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.726996	64.155065	9.538120	50.766222	0.050343	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	515,030	138,330	121,694	57,752	138,931	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.944346	9.610254	0.486140	4.012227	0.005076	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/21/2024 9:54 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
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: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/21/2024 9:54 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	261,387					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,507,708				14.00
15.00	01500	PHARMACY	0	0	81,656			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	365,453,719		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	14,394	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	76,366	476,217	3,834	19,123,508	7,986	30.00
31.00	03100	INTENSIVE CARE UNIT	19,186	184,352	1,081	2,632,841	936	31.00
40.00	04000	SUBPROVIDER - IPF	37,314	35,315	149	7,449,785	5,472	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,918	1,832,928	10,900	45,139,523	0	50.00
51.00	05100	RECOVERY ROOM	20,478	10,001	327	11,868,385	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	80,709	24,794	13,929,788	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,643	77,447	1,304	16,365,322	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,056	12,449	0	7,213,009	0	55.00
56.00	05600	RADIOISOTOPE	45	2,142	4,868	7,295,172	0	56.00
57.00	05700	CT SCAN	116	56,147	20,024	56,033,665	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	246	5,760	303	9,778,151	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	1,218,181	61	47,777,010	0	60.00
64.00	06400	INTRAVENOUS THERAPY	5,605	24,438	590	1,844,145	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	81,742	21	10,693,555	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,400	25	9,336,696	0	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	28,930	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	196	0	1,330,887	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	626,728	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,760	25,646	221	14,373,974	0	69.00
69.01	03140	CARDIAC REHABILITATION	2,851	800	152	634,484	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,329	677	2,381,431	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,722,024	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,219,491	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	22,174,184	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	27,175	29,719	10,504	10,080,042	0	90.00
91.00	09100	EMERGENCY	30,567	341,790	1,821	39,400,989	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.30	09930	OOT	0	0	0	0	0	99.30
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	259,326	4,507,708	81,656	365,453,719	14,394	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,061	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	0	0	0	194.03
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)	2,523,605	521,484	2,564,106	237,539	112,099	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.654669	0.115687	31.401318	0.000650	7.787898	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	76,239	20,461	183,434	71,729	30,065	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/21/2024 9:54 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.291671	0.004539	2.246424	0.000195	2.088718	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: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,993,368		16,993,368	0	16,993,368	30.00
31.00	03100	INTENSIVE CARE UNIT	3,276,400		3,276,400	0	3,276,400	31.00
40.00	04000	SUBPROVIDER - IPF	7,389,535		7,389,535	0	7,389,535	40.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,162,970		8,162,970	21,028	8,183,998	50.00
51.00	05100	RECOVERY ROOM	2,124,164		2,124,164	0	2,124,164	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	936,685		936,685	0	936,685	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,020,183		3,020,183	0	3,020,183	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,244,282		1,244,282	0	1,244,282	55.00
56.00	05600	RADIOISOTOPE	966,268		966,268	0	966,268	56.00
57.00	05700	CT SCAN	1,638,092		1,638,092	0	1,638,092	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	421,209		421,209	0	421,209	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	4,536,141		4,536,141	0	4,536,141	60.00
64.00	06400	INTRAVENOUS THERAPY	677,012		677,012	0	677,012	64.00
65.00	06500	RESPIRATORY THERAPY	2,859,431	0	2,859,431	4,571	2,864,002	65.00
66.00	06600	PHYSICAL THERAPY	3,306,026	0	3,306,026	0	3,306,026	66.00
66.01	03340	CLINICAL NUTRITION	243,260	0	243,260	0	243,260	66.01
67.00	06700	OCCUPATIONAL THERAPY	340,687	0	340,687	0	340,687	67.00
68.00	06800	SPEECH PATHOLOGY	301,311	0	301,311	0	301,311	68.00
69.00	06900	ELECTROCARDIOLOGY	2,296,084		2,296,084	10,476	2,306,560	69.00
69.01	03140	CARDIAC REHABILITATION	258,319		258,319	0	258,319	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	271,096		271,096	4,571	275,667	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,868,572		4,868,572	0	4,868,572	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,095,964		2,095,964	0	2,095,964	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,003,571		5,003,571	0	5,003,571	73.00
74.00	07400	RENAL DIALYSIS	9		9	0	9	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,811,415		5,811,415	0	5,811,415	90.00
91.00	09100	EMERGENCY	6,355,865		6,355,865	28,263	6,384,128	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,362,288		1,362,288		1,362,288	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.30	09930	OOT	0		0		0	99.30
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	86,760,207	0	86,760,207	68,909	86,829,116	200.00
201.00		Less Observation Beds	1,362,288		1,362,288		1,362,288	201.00
202.00		Total (see instructions)	85,397,919	0	85,397,919	68,909	85,466,828	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,088,951		18,088,951			30.00
31.00	03100	INTENSIVE CARE UNIT	2,632,841		2,632,841			31.00
40.00	04000	SUBPROVIDER - IPF	7,449,785		7,449,785			40.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,142,319	30,997,204	45,139,523	0.180839	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,437,416	10,430,969	11,868,385	0.178977	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,993,360	9,936,428	13,929,788	0.067243	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,871,921	14,493,401	16,365,322	0.184548	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	45,435	7,167,574	7,213,009	0.172505	0.000000	55.00
56.00	05600	RADIOISOTOPE	314,176	6,980,996	7,295,172	0.132453	0.000000	56.00
57.00	05700	CT SCAN	10,590,471	45,443,194	56,033,665	0.029234	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	763,758	9,014,393	9,778,151	0.043077	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	12,497,465	35,279,545	47,777,010	0.094944	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	20,695	1,823,450	1,844,145	0.367114	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,923,862	6,769,693	10,693,555	0.267398	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,220,072	8,116,624	9,336,696	0.354089	0.000000	66.00
66.01	03340	CLINICAL NUTRITION	0	28,930	28,930	8.408572	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	292,723	1,038,164	1,330,887	0.255985	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	131,110	495,618	626,728	0.480768	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,576,292	10,797,682	14,373,974	0.159739	0.000000	69.00
69.01	03140	CARDIAC REHABILITATION	672	633,812	634,484	0.407132	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	61,019	2,320,412	2,381,431	0.113837	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,262,921	1,459,103	4,722,024	1.031035	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,892,525	1,326,966	3,219,491	0.651023	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,447,856	13,726,328	22,174,184	0.225648	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	431,734	9,648,308	10,080,042	0.576527	0.000000	90.00
91.00	09100	EMERGENCY	8,192,277	31,208,712	39,400,989	0.161312	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	202,515	832,042	1,034,557	1.316784	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.30	09930	OOT	0	0	0			99.30
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	105,484,171	259,969,548	365,453,719			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	105,484,171	259,969,548	365,453,719			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio 11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.181304	50.00
51.00	05100	RECOVERY ROOM	0.178977	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.067243	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184548	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.172505	55.00
56.00	05600	RADIOISOTOPE	0.132453	56.00
57.00	05700	CT SCAN	0.029234	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.043077	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.094944	60.00
64.00	06400	INTRAVENOUS THERAPY	0.367114	64.00
65.00	06500	RESPIRATORY THERAPY	0.267825	65.00
66.00	06600	PHYSICAL THERAPY	0.354089	66.00
66.01	03340	CLINICAL NUTRITION	8.408572	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.255985	67.00
68.00	06800	SPEECH PATHOLOGY	0.480768	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160468	69.00
69.01	03140	CARDIAC REHABILITATION	0.407132	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.115757	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.031035	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.651023	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225648	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.576527	90.00
91.00	09100	EMERGENCY	0.162030	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.316784	92.00
		OTHER REIMBURSABLE COST CENTERS		
99.30	09930	OOT		99.30
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/21/2024 9:54 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,993,368		16,993,368	0	16,993,368	30.00
31.00	03100	INTENSIVE CARE UNIT	3,276,400		3,276,400	0	3,276,400	31.00
40.00	04000	SUBPROVIDER - IPF	7,389,535		7,389,535	0	7,389,535	40.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,162,970		8,162,970	21,028	8,183,998	50.00
51.00	05100	RECOVERY ROOM	2,124,164		2,124,164	0	2,124,164	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	936,685		936,685	0	936,685	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,020,183		3,020,183	0	3,020,183	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,244,282		1,244,282	0	1,244,282	55.00
56.00	05600	RADIOISOTOPE	966,268		966,268	0	966,268	56.00
57.00	05700	CT SCAN	1,638,092		1,638,092	0	1,638,092	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	421,209		421,209	0	421,209	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	4,536,141		4,536,141	0	4,536,141	60.00
64.00	06400	INTRAVENOUS THERAPY	677,012		677,012	0	677,012	64.00
65.00	06500	RESPIRATORY THERAPY	2,859,431	0	2,859,431	4,571	2,864,002	65.00
66.00	06600	PHYSICAL THERAPY	3,306,026	0	3,306,026	0	3,306,026	66.00
66.01	03340	CLINICAL NUTRITION	243,260	0	243,260	0	243,260	66.01
67.00	06700	OCCUPATIONAL THERAPY	340,687	0	340,687	0	340,687	67.00
68.00	06800	SPEECH PATHOLOGY	301,311	0	301,311	0	301,311	68.00
69.00	06900	ELECTROCARDIOLOGY	2,296,084		2,296,084	10,476	2,306,560	69.00
69.01	03140	CARDIAC REHABILITATION	258,319		258,319	0	258,319	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	271,096		271,096	4,571	275,667	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,868,572		4,868,572	0	4,868,572	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,095,964		2,095,964	0	2,095,964	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,003,571		5,003,571	0	5,003,571	73.00
74.00	07400	RENAL DIALYSIS	9		9	0	9	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,811,415		5,811,415	0	5,811,415	90.00
91.00	09100	EMERGENCY	6,355,865		6,355,865	28,263	6,384,128	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,362,288		1,362,288		1,362,288	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.30	09930	OOT	0		0		0	99.30
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	86,760,207	0	86,760,207	68,909	86,829,116	200.00
201.00		Less Observation Beds	1,362,288		1,362,288		1,362,288	201.00
202.00		Total (see instructions)	85,397,919	0	85,397,919	68,909	85,466,828	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/21/2024 9:54 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,088,951		18,088,951			30.00
31.00	03100	INTENSIVE CARE UNIT	2,632,841		2,632,841			31.00
40.00	04000	SUBPROVIDER - IPF	7,449,785		7,449,785			40.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,142,319	30,997,204	45,139,523	0.180839	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,437,416	10,430,969	11,868,385	0.178977	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,993,360	9,936,428	13,929,788	0.067243	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,871,921	14,493,401	16,365,322	0.184548	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	45,435	7,167,574	7,213,009	0.172505	0.000000	55.00
56.00	05600	RADIOISOTOPE	314,176	6,980,996	7,295,172	0.132453	0.000000	56.00
57.00	05700	CT SCAN	10,590,471	45,443,194	56,033,665	0.029234	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	763,758	9,014,393	9,778,151	0.043077	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	12,497,465	35,279,545	47,777,010	0.094944	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	20,695	1,823,450	1,844,145	0.367114	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,923,862	6,769,693	10,693,555	0.267398	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,220,072	8,116,624	9,336,696	0.354089	0.000000	66.00
66.01	03340	CLINICAL NUTRITION	0	28,930	28,930	8.408572	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	292,723	1,038,164	1,330,887	0.255985	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	131,110	495,618	626,728	0.480768	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,576,292	10,797,682	14,373,974	0.159739	0.000000	69.00
69.01	03140	CARDIAC REHABILITATION	672	633,812	634,484	0.407132	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	61,019	2,320,412	2,381,431	0.113837	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,262,921	1,459,103	4,722,024	1.031035	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,892,525	1,326,966	3,219,491	0.651023	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,447,856	13,726,328	22,174,184	0.225648	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	431,734	9,648,308	10,080,042	0.576527	0.000000	90.00
91.00	09100	EMERGENCY	8,192,277	31,208,712	39,400,989	0.161312	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	202,515	832,042	1,034,557	1.316784	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.30	09930	OOT	0	0	0			99.30
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	105,484,171	259,969,548	365,453,719			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	105,484,171	259,969,548	365,453,719			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/21/2024 9:54 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.181304	50.00
51.00	05100	RECOVERY ROOM	0.178977	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.067243	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184548	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.172505	55.00
56.00	05600	RADIOISOTOPE	0.132453	56.00
57.00	05700	CT SCAN	0.029234	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.043077	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.094944	60.00
64.00	06400	INTRAVENOUS THERAPY	0.367114	64.00
65.00	06500	RESPIRATORY THERAPY	0.267825	65.00
66.00	06600	PHYSICAL THERAPY	0.354089	66.00
66.01	03340	CLINICAL NUTRITION	8.408572	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.255985	67.00
68.00	06800	SPEECH PATHOLOGY	0.480768	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160468	69.00
69.01	03140	CARDIAC REHABILITATION	0.407132	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.115757	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.031035	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.651023	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225648	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.576527	90.00
91.00	09100	EMERGENCY	0.162030	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.316784	92.00
		OTHER REIMBURSABLE COST CENTERS		
99.30	09930	OOT		99.30
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/21/2024 9:54 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,162,970	917,865	7,245,105	0	0	50.00
51.00	05100	RECOVERY ROOM	2,124,164	48,797	2,075,367	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	936,685	67,143	869,542	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,020,183	246,224	2,773,959	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,244,282	27,196	1,217,086	0	0	55.00
56.00	05600	RADIOISOTOPE	966,268	75,626	890,642	0	0	56.00
57.00	05700	CT SCAN	1,638,092	79,008	1,559,084	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	421,209	16,620	404,589	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,536,141	184,826	4,351,315	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	677,012	30,596	646,416	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,859,431	192,133	2,667,298	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,306,026	216,498	3,089,528	0	0	66.00
66.01	03340	CLINICAL NUTRITION	243,260	5,086	238,174	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	340,687	7,348	333,339	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	301,311	16,387	284,924	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,296,084	134,015	2,162,069	0	0	69.00
69.01	03140	CARDIAC REHABILITATION	258,319	6,006	252,313	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	271,096	37,594	233,502	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,868,572	90,277	4,778,295	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,095,964	39,083	2,056,881	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,003,571	95,951	4,907,620	0	0	73.00
74.00	07400	RENAL DIALYSIS	9	0	9	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,811,415	355,930	5,455,485	0	0	90.00
91.00	09100	EMERGENCY	6,355,865	292,765	6,063,100	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,362,288	110,672	1,251,616	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.30	09930	OOT	0	0	0	0	0	99.30
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
200.00		Subtotal (sum of lines 50 thru 199)	59,100,904	3,293,646	55,807,258	0	0	200.00
201.00		Less Observation Beds	1,362,288	110,672	1,251,616	0	0	201.00
202.00		Total (line 200 minus line 201)	57,738,616	3,182,974	54,555,642	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/21/2024 9:54 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	8,162,970	45,139,523	0.180839		50.00
51.00	05100	RECOVERY ROOM	2,124,164	11,868,385	0.178977		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	936,685	13,929,788	0.067243		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,020,183	16,365,322	0.184548		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,244,282	7,213,009	0.172505		55.00
56.00	05600	RADIOISOTOPE	966,268	7,295,172	0.132453		56.00
57.00	05700	CT SCAN	1,638,092	56,033,665	0.029234		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	421,209	9,778,151	0.043077		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000		59.00
60.00	06000	LABORATORY	4,536,141	47,777,010	0.094944		60.00
64.00	06400	INTRAVENOUS THERAPY	677,012	1,844,145	0.367114		64.00
65.00	06500	RESPIRATORY THERAPY	2,859,431	10,693,555	0.267398		65.00
66.00	06600	PHYSICAL THERAPY	3,306,026	9,336,696	0.354089		66.00
66.01	03340	CLINICAL NUTRITION	243,260	28,930	8.408572		66.01
67.00	06700	OCCUPATIONAL THERAPY	340,687	1,330,887	0.255985		67.00
68.00	06800	SPEECH PATHOLOGY	301,311	626,728	0.480768		68.00
69.00	06900	ELECTROCARDIOLOGY	2,296,084	14,373,974	0.159739		69.00
69.01	03140	CARDIAC REHABILITATION	258,319	634,484	0.407132		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	271,096	2,381,431	0.113837		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,868,572	4,722,024	1.031035		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,095,964	3,219,491	0.651023		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,003,571	22,174,184	0.225648		73.00
74.00	07400	RENAL DIALYSIS	9	0	0.000000		74.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	5,811,415	10,080,042	0.576527		90.00
91.00	09100	EMERGENCY	6,355,865	39,400,989	0.161312		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,362,288	1,034,557	1.316784		92.00
		OTHER REIMBURSABLE COST CENTERS					
99.30	09930	OOT	0	0	0.000000		99.30
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0.000000		102.00
200.00		Subtotal (sum of lines 50 thru 199)	59,100,904	337,282,142			200.00
201.00		Less Observation Beds	1,362,288	0			201.00
202.00		Total (line 200 minus line 201)	57,738,616	337,282,142			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,380,539	0	1,380,539	8,682	159.01	30.00
31.00	INTENSIVE CARE UNIT	165,255		165,255	936	176.55	31.00
40.00	SUBPROVIDER - IPF	330,011	0	330,011	5,472	60.31	40.00
43.00	NURSERY	0		0	0	0.00	43.00
200.00	Total (lines 30 through 199)	1,875,805		1,875,805	15,090		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,526	719,679				30.00
31.00	INTENSIVE CARE UNIT	464	81,919				31.00
40.00	SUBPROVIDER - IPF	975	58,802				40.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	5,965	860,400				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	917,865	45,139,523	0.020334	3,497,755	71,123	50.00
51.00	05100	RECOVERY ROOM	48,797	11,868,385	0.004112	339,600	1,396	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	67,143	13,929,788	0.004820	550,770	2,655	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	246,224	16,365,322	0.015045	1,311,210	19,727	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	27,196	7,213,009	0.003770	2,977	11	55.00
56.00	05600	RADIOISOTOPE	75,626	7,295,172	0.010367	104,950	1,088	56.00
57.00	05700	CT SCAN	79,008	56,033,665	0.001410	5,277,477	7,441	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	16,620	9,778,151	0.001700	318,158	541	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	184,826	47,777,010	0.003869	6,016,708	23,279	60.00
64.00	06400	INTRAVENOUS THERAPY	30,596	1,844,145	0.016591	6,970	116	64.00
65.00	06500	RESPIRATORY THERAPY	192,133	10,693,555	0.017967	2,089,139	37,536	65.00
66.00	06600	PHYSICAL THERAPY	216,498	9,336,696	0.023188	721,518	16,731	66.00
66.01	03340	CLINICAL NUTRITION	5,086	28,930	0.175804	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	7,348	1,330,887	0.005521	143,977	795	67.00
68.00	06800	SPEECH PATHOLOGY	16,387	626,728	0.026147	105,398	2,756	68.00
69.00	06900	ELECTROCARDIOLOGY	134,015	14,373,974	0.009323	1,508,925	14,068	69.00
69.01	03140	CARDIAC REHABILITATION	6,006	634,484	0.009466	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	37,594	2,381,431	0.015786	40,090	633	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	90,277	4,722,024	0.019118	1,334,963	25,522	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,083	3,219,491	0.012139	590,910	7,173	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	95,951	22,174,184	0.004327	4,385,856	18,978	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	355,930	10,080,042	0.035310	0	0	90.00
91.00	09100	EMERGENCY	292,765	39,400,989	0.007430	3,814,437	28,341	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	110,672	1,034,557	0.106975	102,122	10,925	92.00
200.00		Total (lines 50 through 199)	3,293,646	337,282,142		32,263,910	290,835	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	8,682	0.00	4,526	30.00
31.00	03100	INTENSIVE CARE UNIT		0	936	0.00	464	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	5,472	0.00	975	40.00
43.00	04300	NURSERY		0	0	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	15,090		5,965	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		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	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: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	45,139,523	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	11,868,385	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,929,788	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,365,322	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	7,213,009	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	7,295,172	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	56,033,665	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	9,778,151	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	47,777,010	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,844,145	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,693,555	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,336,696	0.000000	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	28,930	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,330,887	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	626,728	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,373,974	0.000000	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	634,484	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,381,431	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,722,024	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,219,491	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	22,174,184	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	10,080,042	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	39,400,989	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,034,557	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	337,282,142		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	3,497,755	0	9,081,095	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	339,600	0	2,803,618	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	550,770	0	1,298,917	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,311,210	0	5,509,231	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	2,977	0	1,810,498	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	104,950	0	1,033,174	0	56.00
57.00	05700	CT SCAN	0.000000	5,277,477	0	12,792,406	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	318,158	0	2,711,270	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	6,016,708	0	4,189,800	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	6,970	0	636,545	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,089,139	0	1,285,342	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	721,518	0	1,490	0	66.00
66.01	03340	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	143,977	0	1,100	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	105,398	0	36,866	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,508,925	0	3,244,033	0	69.00
69.01	03140	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	40,090	0	1,409,685	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,334,963	0	343,991	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	590,910	0	265,078	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,385,856	0	6,160,507	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	376,743	0	90.00
91.00	09100	EMERGENCY	0.000000	3,814,437	0	7,297,855	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	102,122	0	200,008	0	92.00
200.00		Total (lines 50 through 199)		32,263,910	0	62,489,252	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.180839	9,081,095	0	0	1,642,216	50.00
51.00	05100	RECOVERY ROOM	0.178977	2,803,618	0	0	501,783	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.067243	1,298,917	0	0	87,343	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184548	5,509,231	0	0	1,016,718	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.172505	1,810,498	0	0	312,320	55.00
56.00	05600	RADIOISOTOPE	0.132453	1,033,174	0	0	136,847	56.00
57.00	05700	CT SCAN	0.029234	12,792,406	0	0	373,973	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.043077	2,711,270	0	0	116,793	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.094944	4,189,800	0	0	397,796	60.00
64.00	06400	INTRAVENOUS THERAPY	0.367114	636,545	0	0	233,685	64.00
65.00	06500	RESPIRATORY THERAPY	0.267398	1,285,342	0	0	343,698	65.00
66.00	06600	PHYSICAL THERAPY	0.354089	1,490	0	0	528	66.00
66.01	03340	CLINICAL NUTRITION	8.408572	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.255985	1,100	0	0	282	67.00
68.00	06800	SPEECH PATHOLOGY	0.480768	36,866	0	0	17,724	68.00
69.00	06900	ELECTROCARDIOLOGY	0.159739	3,244,033	0	0	518,199	69.00
69.01	03140	CARDIAC REHABILITATION	0.407132	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.113837	1,409,685	0	0	160,474	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.031035	343,991	0	0	354,667	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.651023	265,078	0	0	172,572	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225648	6,160,507	0	15,516	1,390,106	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.576527	376,743	0	0	217,203	90.00
91.00	09100	EMERGENCY	0.161312	7,297,855	0	0	1,177,232	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.316784	200,008	0	0	263,367	92.00
200.00		Subtotal (see instructions)		62,489,252	0	15,516	9,435,526	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		62,489,252	0	15,516	9,435,526	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
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
66.00	06600	PHYSICAL THERAPY	0	0		66.00
66.01	03340	CLINICAL NUTRITION	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03140	CARDIAC REHABILITATION	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
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	3,501		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		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		Subtotal (see instructions)	0	3,501		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	3,501		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	917,865	45,139,523	0.020334	0	0	50.00
51.00	05100	RECOVERY ROOM	48,797	11,868,385	0.004112	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	67,143	13,929,788	0.004820	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	246,224	16,365,322	0.015045	11,249	169	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	27,196	7,213,009	0.003770	0	0	55.00
56.00	05600	RADIOISOTOPE	75,626	7,295,172	0.010367	0	0	56.00
57.00	05700	CT SCAN	79,008	56,033,665	0.001410	59,936	85	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	16,620	9,778,151	0.001700	4,370	7	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	184,826	47,777,010	0.003869	232,536	900	60.00
64.00	06400	INTRAVENOUS THERAPY	30,596	1,844,145	0.016591	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	192,133	10,693,555	0.017967	68,390	1,229	65.00
66.00	06600	PHYSICAL THERAPY	216,498	9,336,696	0.023188	15,906	369	66.00
66.01	03340	CLINICAL NUTRITION	5,086	28,930	0.175804	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	7,348	1,330,887	0.005521	7,483	41	67.00
68.00	06800	SPEECH PATHOLOGY	16,387	626,728	0.026147	400	10	68.00
69.00	06900	ELECTROCARDIOLOGY	134,015	14,373,974	0.009323	18,300	171	69.00
69.01	03140	CARDIAC REHABILITATION	6,006	634,484	0.009466	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	37,594	2,381,431	0.015786	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	90,277	4,722,024	0.019118	14,144	270	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,083	3,219,491	0.012139	309	4	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	95,951	22,174,184	0.004327	76,369	330	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	355,930	10,080,042	0.035310	0	0	90.00
91.00	09100	EMERGENCY	292,765	39,400,989	0.007430	132,493	984	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,034,557	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	3,182,974	337,282,142		641,885	4,569	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		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	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: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	45,139,523	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	11,868,385	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,929,788	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,365,322	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	7,213,009	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	7,295,172	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	56,033,665	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	9,778,151	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	47,777,010	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,844,145	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,693,555	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,336,696	0.000000	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	28,930	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,330,887	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	626,728	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,373,974	0.000000	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	634,484	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,381,431	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,722,024	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,219,491	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	22,174,184	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	10,080,042	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	39,400,989	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,034,557	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	337,282,142		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	11,249	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	59,936	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	4,370	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	232,536	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	68,390	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	15,906	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	7,483	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	400	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	18,300	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	14,144	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	309	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	76,369	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	90,113	0	90.00
91.00	09100	EMERGENCY	0.000000	132,493	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)		641,885	0	90,113	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.180839	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.178977	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.067243	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184548	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.172505	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.132453	0	0	0	0	56.00
57.00	05700	CT SCAN	0.029234	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.043077	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.094944	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.367114	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.267398	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.354089	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION	8.408572	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.255985	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.480768	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.159739	0	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION	0.407132	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.113837	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.031035	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.651023	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225648	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.576527	90,113	0	0	51,953	90.00
91.00	09100	EMERGENCY	0.161312	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.316784	0	0	0	0	92.00
200.00		Subtotal (see instructions)		90,113	0	0	51,953	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		90,113	0	0	51,953	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
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
66.00	06600	PHYSICAL THERAPY	0	0		66.00
66.01	03340	CLINICAL NUTRITION	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03140	CARDIAC REHABILITATION	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
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
74.00	07400	RENAL DIALYSIS	0	0		74.00
		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		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I | Date/Time Prepared: 5/21/2024 9:54 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,380,539	0	1,380,539	8,682	159.01	30.00
31.00	INTENSIVE CARE UNIT	165,255		165,255	936	176.55	31.00
40.00	SUBPROVIDER - IPF	330,011	0	330,011	5,472	60.31	40.00
43.00	NURSERY	0		0	0	0.00	43.00
200.00	Total (lines 30 through 199)	1,875,805		1,875,805	15,090		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	91	14,470				30.00
31.00	INTENSIVE CARE UNIT	6	1,059				31.00
40.00	SUBPROVIDER - IPF	23	1,387				40.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	120	16,916				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/21/2024 9:54 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	917,865	45,139,523	0.020334	0	0	50.00
51.00	05100	RECOVERY ROOM	48,797	11,868,385	0.004112	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	67,143	13,929,788	0.004820	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	246,224	16,365,322	0.015045	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	27,196	7,213,009	0.003770	0	0	55.00
56.00	05600	RADIOISOTOPE	75,626	7,295,172	0.010367	0	0	56.00
57.00	05700	CT SCAN	79,008	56,033,665	0.001410	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	16,620	9,778,151	0.001700	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	184,826	47,777,010	0.003869	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	30,596	1,844,145	0.016591	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	192,133	10,693,555	0.017967	0	0	65.00
66.00	06600	PHYSICAL THERAPY	216,498	9,336,696	0.023188	0	0	66.00
66.01	03340	CLINICAL NUTRITION	5,086	28,930	0.175804	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	7,348	1,330,887	0.005521	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	16,387	626,728	0.026147	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	134,015	14,373,974	0.009323	0	0	69.00
69.01	03140	CARDIAC REHABILITATION	6,006	634,484	0.009466	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	37,594	2,381,431	0.015786	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	90,277	4,722,024	0.019118	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,083	3,219,491	0.012139	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	95,951	22,174,184	0.004327	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	355,930	10,080,042	0.035310	0	0	90.00
91.00	09100	EMERGENCY	292,765	39,400,989	0.007430	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	110,672	1,034,557	0.106975	0	0	92.00
200.00		Total (lines 50 through 199)	3,293,646	337,282,142		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/21/2024 9:54 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	8,682	0.00	91	30.00
31.00	03100	INTENSIVE CARE UNIT		0	936	0.00	6	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	5,472	0.00	23	40.00
43.00	04300	NURSERY		0	0	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	15,090		120	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/21/2024 9:54 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		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	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: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/21/2024 9:54 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	45,139,523	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	11,868,385	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,929,788	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,365,322	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	7,213,009	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	7,295,172	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	56,033,665	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	9,778,151	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	47,777,010	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,844,145	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,693,555	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,336,696	0.000000	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	28,930	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,330,887	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	626,728	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,373,974	0.000000	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	634,484	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,381,431	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,722,024	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,219,491	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	22,174,184	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	10,080,042	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	39,400,989	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,034,557	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	337,282,142		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/21/2024 9:54 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/21/2024 9:54 am

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	917,865	45,139,523	0.020334	0	0	50.00
51.00	05100	RECOVERY ROOM	48,797	11,868,385	0.004112	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	67,143	13,929,788	0.004820	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	246,224	16,365,322	0.015045	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	27,196	7,213,009	0.003770	0	0	55.00
56.00	05600	RADIOISOTOPE	75,626	7,295,172	0.010367	0	0	56.00
57.00	05700	CT SCAN	79,008	56,033,665	0.001410	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	16,620	9,778,151	0.001700	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	184,826	47,777,010	0.003869	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	30,596	1,844,145	0.016591	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	192,133	10,693,555	0.017967	0	0	65.00
66.00	06600	PHYSICAL THERAPY	216,498	9,336,696	0.023188	0	0	66.00
66.01	03340	CLINICAL NUTRITION	5,086	28,930	0.175804	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	7,348	1,330,887	0.005521	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	16,387	626,728	0.026147	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	134,015	14,373,974	0.009323	0	0	69.00
69.01	03140	CARDIAC REHABILITATION	6,006	634,484	0.009466	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	37,594	2,381,431	0.015786	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	90,277	4,722,024	0.019118	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,083	3,219,491	0.012139	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	95,951	22,174,184	0.004327	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	355,930	10,080,042	0.035310	0	0	90.00
91.00	09100	EMERGENCY	292,765	39,400,989	0.007430	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,034,557	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	3,182,974	337,282,142		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/21/2024 9:54 am

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		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	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: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/21/2024 9:54 am

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	45,139,523	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	11,868,385	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,929,788	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,365,322	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	7,213,009	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	7,295,172	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	56,033,665	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	9,778,151	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	47,777,010	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,844,145	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,693,555	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,336,696	0.000000	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	28,930	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,330,887	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	626,728	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,373,974	0.000000	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	634,484	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,381,431	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,722,024	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,219,491	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	22,174,184	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	10,080,042	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	39,400,989	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,034,557	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	337,282,142		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/21/2024 9:54 am

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,682	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,682	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)	7,986	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	4,526	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	16,993,368	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	16,993,368	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)	16,993,368	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)	1,957.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	8,858,785	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)	8,858,785	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,276,400	936	3,500.43	464	1,624,200	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)	6,382,750	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)	16,865,735	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)	801,598	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	290,835	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,092,433	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	15,773,302	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	696	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,957.31	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,362,288	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,380,539	16,993,368	0.081240	1,362,288	110,672	90.00
91.00	Nursing Program cost	0	16,993,368	0.000000	1,362,288	0	91.00
92.00	Allied health cost	0	16,993,368	0.000000	1,362,288	0	92.00
93.00	All other Medical Education	0	16,993,368	0.000000	1,362,288	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/21/2024 9:54 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,472	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,472	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)	5,472	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	975	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,389,535	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,389,535	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)	7,389,535	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)	1,350.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,316,669	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,316,669	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	108,573	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)	1,425,242	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)	58,802	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	4,569	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	63,371	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,361,871	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/21/2024 9:54 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	330,011	7,389,535	0.044659	0	0	90.00
91.00	Nursing Program cost	0	7,389,535	0.000000	0	0	91.00
92.00	Allied health cost	0	7,389,535	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,389,535	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/21/2024 9:54 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,682	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,682	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)	7,986	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	91	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	16,993,368	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	16,993,368	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)	16,993,368	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)	1,957.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	178,115	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)	178,115	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/21/2024 9:54 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,276,400	936	3,500.43	6	21,003	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	199,118	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)	15,529	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)	15,529	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	183,589	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	696	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,957.31	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,362,288	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/21/2024 9:54 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,380,539	16,993,368	0.081240	1,362,288	110,672	90.00
91.00	Nursing Program cost	0	16,993,368	0.000000	1,362,288	0	91.00
92.00	Allied health cost	0	16,993,368	0.000000	1,362,288	0	92.00
93.00	All other Medical Education	0	16,993,368	0.000000	1,362,288	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/21/2024 9:54 am
	Title XIX	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,472	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,472	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)	5,472	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	23	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,389,535	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,389,535	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)	7,389,535	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)	1,350.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	31,060	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)	31,060	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/21/2024 9:54 am

Title XIX | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	31,060	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)	1,387	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)	1,387	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	29,673	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/21/2024 9:54 am
	Title XIX	Subprovider - IPF	PPS

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	330,011	7,389,535	0.044659	0	0	90.00
91.00	Nursing Program cost	0	7,389,535	0.000000	0	0	91.00
92.00	Allied health cost	0	7,389,535	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,389,535	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		7,745,514		30.00
31.00	03100	INTENSIVE CARE UNIT		1,222,640		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.181304	3,497,755	634,157	50.00
51.00	05100	RECOVERY ROOM	0.178977	339,600	60,781	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.067243	550,770	37,035	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184548	1,311,210	241,981	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.172505	2,977	514	55.00
56.00	05600	RADIOISOTOPE	0.132453	104,950	13,901	56.00
57.00	05700	CT SCAN	0.029234	5,277,477	154,282	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.043077	318,158	13,705	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.094944	6,016,708	571,250	60.00
64.00	06400	INTRAVENOUS THERAPY	0.367114	6,970	2,559	64.00
65.00	06500	RESPIRATORY THERAPY	0.267825	2,089,139	559,524	65.00
66.00	06600	PHYSICAL THERAPY	0.354089	721,518	255,482	66.00
66.01	03340	CLINICAL NUTRITION	8.408572	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.255985	143,977	36,856	67.00
68.00	06800	SPEECH PATHOLOGY	0.480768	105,398	50,672	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160468	1,508,925	242,134	69.00
69.01	03140	CARDIAC REHABILITATION	0.407132	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.115757	40,090	4,641	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.031035	1,334,963	1,376,394	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.651023	590,910	384,696	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225648	4,385,856	989,660	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.576527	0	0	90.00
91.00	09100	EMERGENCY	0.162030	3,814,437	618,053	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.316784	102,122	134,473	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		32,263,910	6,382,750	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)		32,263,910		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF		1,192,574		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.181304	0	0	50.00
51.00	05100	RECOVERY ROOM	0.178977	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.067243	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184548	11,249	2,076	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.172505	0	0	55.00
56.00	05600	RADIOISOTOPE	0.132453	0	0	56.00
57.00	05700	CT SCAN	0.029234	59,936	1,752	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.043077	4,370	188	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.094944	232,536	22,078	60.00
64.00	06400	INTRAVENOUS THERAPY	0.367114	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.267825	68,390	18,317	65.00
66.00	06600	PHYSICAL THERAPY	0.354089	15,906	5,632	66.00
66.01	03340	CLINICAL NUTRITION	8.408572	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.255985	7,483	1,916	67.00
68.00	06800	SPEECH PATHOLOGY	0.480768	400	192	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160468	18,300	2,937	69.00
69.01	03140	CARDIAC REHABILITATION	0.407132	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.115757	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.031035	14,144	14,583	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.651023	309	201	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225648	76,369	17,233	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.576527	0	0	90.00
91.00	09100	EMERGENCY	0.162030	132,493	21,468	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.316784	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		641,885	108,573	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)		641,885		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0034	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/21/2024 9:54 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	7,605,743	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,662,512	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	70,543	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	39,617	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	90.09	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.16	30.00
31.00	Percentage of Medicaid patient days (see instructions)	15.25	31.00
32.00	Sum of lines 30 and 31	19.41	32.00
33.00	Allowable disproportionate share percentage (see instructions)	5.39	33.00
34.00	Disproportionate share adjustment (see instructions)	138,365	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0034	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/21/2024 9:54 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,874,403,459	5,938,006,757	35.00
35.01	Factor 3 (see instructions)	0.000076569	0.000076537	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	526,366	454,477	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	393,693	114,240	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	507,933		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	11,024,713		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	11,940,484		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	11,711,541	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	780,255	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	35,724	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	12,527,520	59.00
60.00	Primary payer payments	13,010	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	12,514,510	61.00
62.00	Deductibles billed to program beneficiaries	1,321,028	62.00
63.00	Coinsurance billed to program beneficiaries	15,200	63.00
64.00	Allowable bad debts (see instructions)	535,824	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	348,286	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	499,704	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	11,526,568	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)	0	70.75
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	371	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	-918	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	5,710	70.93
70.94	HRR adjustment amount (see instructions)	-14,111	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0034	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/21/2024 9:54 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		11,517,620	71.00
71.01	Sequestration adjustment (see instructions)		230,352	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		11,434,392	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-147,124	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		363,167	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	513,710	173,118	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	1.0000000000	1.0021446006	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	371	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	1.0000	0.9947	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	-918	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7,605,743	0	7,605,743		7,605,743	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,662,512	0		2,662,512	2,662,512	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	70,543	0	70,543		70,543	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	39,617	0		39,617	39,617	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0539	0.0539	0.0539	0.0539		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	138,365	0	102,488	35,877	138,365	11.00
11.01	Uncompensated care payments	36.00	507,933	0	393,693	114,240	507,933	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	11,024,713	0	8,172,467	2,852,246	11,024,713	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	11,940,484	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	11,711,541	0	8,859,295	2,852,246	11,711,541	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	780,255	0	572,260	207,995	780,255	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	35,724	0	35,724	0	35,724	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	9,467,279	3,060,241	12,527,520	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	774,208	0	568,103	206,105	774,208	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	6,047	0	4,157	1,890	6,047	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	780,255	0	572,260	207,995	780,255	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.069621	0.069621		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			659,121		659,121	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				213,057	213,057	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7,605,743	7,605,743		7,605,743	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,662,512		2,662,512	2,662,512	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	70,543	70,543		70,543	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	39,617		39,617	39,617	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0539	0.0539	0.0539		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	138,365	102,488	35,877	138,365	11.00
11.01	Uncompensated care payments	36.00	507,933	393,693	114,240	507,933	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	11,024,713	8,172,467	2,852,246	11,024,713	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	11,940,484	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	11,711,541	8,859,295	2,852,246	11,711,541	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	780,255	572,260	207,995	780,255	16.00
17.00	Special add-on payments for new technologies	54.00	35,724	35,724	0	35,724	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			9,467,279	3,060,241	12,527,520	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	774,208	568,103	206,105	774,208	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	6,047	4,157	1,890	6,047	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	780,255	572,260	207,995	780,255	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	5,710	0	5,710	5,710	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	371	0	371	371	30.01
31.00	HRR adjustment (see instructions)	70.94	-14,111	0	-14,111	-14,111	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-918	0	-918	-918	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part B Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,501	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	9,435,526	2.00
3.00	OPPS or REH payments	8,139,540	3.00
4.00	Outlier payment (see instructions)	7,567	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 including REH direct graduate medical education 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)	3,501	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	15,516	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)	15,516	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	15,516	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	12,015	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)	3,501	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)	8,147,107	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,619,797	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)	6,530,811	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		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)	6,530,811	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	6,530,811	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)	303,763	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	197,446	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	262,360	36.00
37.00	Subtotal (see instructions)	6,728,257	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	6,728,257	40.00
40.01	Sequestration adjustment (see instructions)	134,565	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	6,597,013	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-3,321	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0034	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/21/2024 9:54 am
	Title XVIII	Hospital	PPS

		1.00	
94.00	Total (sum of lines 91 and 93)	0	94.00
		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	0	200.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/21/2024 9:54 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	51,953	2.00
3.00	OPPS or REH payments	28,496	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 including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	28,496	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	8,264	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)	20,232	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		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)	20,232	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	20,232	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	20,232	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	20,232	40.00
40.01	Sequestration adjustment (see instructions)	405	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	19,827	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/21/2024 9:54 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00
		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days		200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		11,402,818		6,652,689	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	08/21/2023	31,574		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	08/21/2023	55,676	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)		31,574		-55,676	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)		11,434,392		6,597,013	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		147,124		3,321	6.02
7.00	Total Medicare program liability (see instructions)		11,287,268		6,593,692	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: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/21/2024 9:54 am

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		913,640		19,827	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		913,640		19,827	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		26,606		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		940,246		19,827	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: 14-0034	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/21/2024 9:54 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part II Date/Time Prepared: 5/21/2024 9:54 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,037,754	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	14.991781	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,037,754	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,037,754	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,037,754	18.00
19.00	Deductibles	105,468	19.00
20.00	Subtotal (line 18 minus line 19)	932,286	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	932,286	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	41,767	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	27,149	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	40,122	25.00
26.00	Subtotal (sum of lines 22 and 24)	959,435	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.98	Recovery of accelerated depreciation.	0	30.98
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	959,435	31.00
31.01	Sequestration adjustment (see instructions)	19,189	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	913,640	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	26,606	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)		
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99.01

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 14-0034	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/21/2024 9:54 am
	Title XVIII		PPS

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/21/2024 9:54 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	101,946	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	44,131,453	0	0	0	4.00
5.00	Other receivable	313,192	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-19,948,859	0	0	0	6.00
7.00	Inventory	1,953,230	0	0	0	7.00
8.00	Prepaid expenses	395,075	0	0	0	8.00
9.00	Other current assets	171,801	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)	27,117,838	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,302,150	0	0	0	12.00
13.00	Land improvements	787,310	0	0	0	13.00
14.00	Accumulated depreciation	-677,522	0	0	0	14.00
15.00	Buildings	47,293,918	0	0	0	15.00
16.00	Accumulated depreciation	-23,979,040	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	5,516,108	0	0	0	19.00
20.00	Accumulated depreciation	-3,347,507	0	0	0	20.00
21.00	Automobiles and trucks	237,182	0	0	0	21.00
22.00	Accumulated depreciation	-221,569	0	0	0	22.00
23.00	Major movable equipment	35,956,160	0	0	0	23.00
24.00	Accumulated depreciation	-26,428,634	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)	36,438,556	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,153,383	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	384,965	587,005	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,538,348	587,005	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	65,094,742	587,005	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	-62,828,076	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,889,143	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	279,490	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	359,451	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-59,299,992	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	29,981,670	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	29,981,670	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-29,318,322	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	94,413,064				52.00
53.00	Specific purpose fund		587,005			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	94,413,064	587,005	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	65,094,742	587,005	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/21/2024 9:54 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		57,294,104		510,584		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		28,426,713				2.00
3.00	Total (sum of line 1 and line 2)		85,720,817		510,584		3.00
4.00	CREDIT ADDITIONS	7,598,635		76,421		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		7,598,635		76,421		10.00
11.00	Subtotal (line 3 plus line 10)		93,319,452		587,005		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		93,319,452		587,005		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	CREDIT ADDITIONS		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/21/2024 9:54 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	18,088,951		18,088,951	1.00
2.00	SUBPROVIDER - IPF	7,449,785		7,449,785	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	25,538,736		25,538,736	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,632,841		2,632,841	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)	2,632,841		2,632,841	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	28,171,577		28,171,577	17.00
18.00	Ancillary services	68,486,068	218,280,485	286,766,553	18.00
19.00	Outpatient services	8,826,525	41,689,061	50,515,586	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.30	OOT	0	0	0	24.30
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NON-REIMBURSABLE	236	163,451	163,687	27.00
27.01	ORGAN ACQUISITION CHARGES	0	0	0	27.01
27.02	PROFESSIONAL FEES	0	0	0	27.02
27.03	EMPLOYEE CHARGES	770,813	5,429,234	6,200,047	27.03
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	106,255,219	265,562,231	371,817,450	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		101,621,690		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)		101,621,690		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0034 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 5/21/2024 9:54 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	371,817,450	1.00
2.00	Less contractual allowances and discounts on patients' accounts	248,131,834	2.00
3.00	Net patient revenues (line 1 minus line 2)	123,685,616	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	101,621,690	4.00
5.00	Net income from service to patients (line 3 minus line 4)	22,063,926	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	3,528,149	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	195	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	258,394	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	226,984	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	3,315,122	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	7,328,844	25.00
26.00	Total (line 5 plus line 25)	29,392,770	26.00
27.00	OTHER EXPENSES	966,057	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	966,057	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	28,426,713	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0034	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/21/2024 9:54 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	774,208	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	6,047	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)	24.58	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)	780,255	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