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: 14-1339	Period: From 10/01/2022 To 09/30/2023	Worksheet S Parts I-III Date/Time Prepared: 2/23/2024 12:01 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/23/2024 Time: 12:01 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by TAYLORVILLE MEMORIAL HOSPITAL (14-1339) for the cost reporting period beginning 10/01/2022 and ending 09/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Kathryn Keim		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	Kathryn Keim			2
3	Signatory Title	SENIOR VICE PRESIDENT & CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	176,560	-50,157	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	443,869	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	620,429	-50,157	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: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2024 12:01 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 201 EAST PLEASANT STREET	PO Box:			1.00
2.00	City: TAYLORVILLE	State: IL	Zip Code: 62568	County: CHRISTIAN	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	TAYLORVILLE MEMORIAL HOSPITAL	141339	99914	1	09/01/2004	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	TAYLORVILLE MEMORIAL-SWB	14Z339	99914		09/01/2004	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2022	09/30/2023	20.00
21.00	Type of Control (see instructions)	2		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2024 12:01 pm

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

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

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

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

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

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

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

		Y/N	IME	Direct GME	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: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2024 12:01 pm

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	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)	N	N	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: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2024 12:01 pm

		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?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2024 12:01 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	33,468	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	Y	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	14H058	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: MEMORIAL HEALTH SYSTEMS	Contractor's Name: MEMORIAL HEALTH SYSTEMS	Contractor's Number: 00131	141.00
142.00	Street: 701 NORTH FIRST STREET	PO Box:		142.00
143.00	City: SPRINGFIELD	State: IL	Zip Code: 62781	143.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1339	Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part I Date/Time Prepared: 2/23/2024 12:01 pm

		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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/23/2024 12:01 pm

		Y/N	Date	
		1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE			
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	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)	Y	12/04/2023	Y	12/04/2023	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/23/2024 12:01 pm

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4300	KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1339	Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part II Date/Time Prepared: 2/23/2024 12:01 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2024 12:01 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	35,724.00	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)		25	9,125	35,724.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	35,724.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2024 12:01 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	883	6	1,512			1.00
2.00	HMO and other (see instructions)	306	75				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	2,604	0	3,761			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	334			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,487	6	5,607			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)	3,487	6	5,607	0.00	257.10	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	257.10	27.00
28.00	Observation Bed Days		10	523			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			8			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: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2024 12:01 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	255	5	456	1.00
2.00	HMO and other (see instructions)			88	21		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	255	5	456	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1339	Period: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/23/2024 12:01 pm

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.295507	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	9,209,528	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	36,569,267	6.00
7.00	Medicaid cost (line 1 times line 6)	10,806,474	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	1,596,946	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	7,795	9.00
10.00	Stand-alone CHIP charges	21,560	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	6,371	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)	1,596,946	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)	275,817	178,153	453,970	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	81,506	178,153	259,659	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,460	0	1,460	22.00
23.00	Cost of charity care (see instructions)	80,046	178,153	258,199	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)	1,412,823	26.00
27.00	Medicare reimbursable bad debts (see instructions)	871,666	27.00
27.01	Medicare allowable bad debts (see instructions)	1,341,024	27.01
28.00	Non-Medicare bad debt amount (see instructions)	71,799	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	490,575	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	748,774	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,345,720	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 2/23/2024 12:01 pm

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)		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)				20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)				21.00
22.00	Payments received from patients for amounts previously written off as charity care				22.00
23.00	Cost of charity care (see instructions)				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?		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		25.00
25.01	Charges for insured patients' liability (see instructions)		25.01
26.00	Bad debt amount (see instructions)		26.00
27.00	Medicare reimbursable bad debts (see instructions)		27.00
27.01	Medicare allowable bad debts (see instructions)		27.01
28.00	Non-Medicare bad debt amount (see instructions)		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/23/2024 12:01 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		4,343,721	4,343,721	572,206	4,915,927	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,253,473	2,253,473	82,917	2,336,390	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	101,583	5,998,086	6,099,669	-19,587	6,080,082	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,963,818	8,953,732	10,917,550	-57,966	10,859,584	5.00
7.00	00700	OPERATION OF PLANT	877,125	1,202,847	2,079,972	-376	2,079,596	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34,832	175,285	210,117	0	210,117	8.00
9.00	00900	HOUSEKEEPING	569,008	121,699	690,707	0	690,707	9.00
10.00	01000	DIETARY	625,867	305,220	931,087	-580,019	351,068	10.00
11.00	01100	CAFETERIA	0	0	0	580,002	580,002	11.00
13.00	01300	NURSING ADMINISTRATION	830,968	29,223	860,191	0	860,191	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	105,671	107,428	213,099	0	213,099	14.00
15.00	01500	PHARMACY	572,771	1,718,871	2,291,642	-1,649,000	642,642	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	548,443	1,892	550,335	0	550,335	16.00
17.00	01700	SOCIAL SERVICE	72,763	0	72,763	0	72,763	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	879,244	0	879,244	14,801	894,045	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,187,684	798,248	3,985,932	-433	3,985,499	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	795,394	1,107,557	1,902,951	-668,715	1,234,236	50.00
53.00	05300	ANESTHESIOLOGY	0	52,794	52,794	-28,683	24,111	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,686,763	731,248	2,418,011	-6,408	2,411,603	54.00
60.00	06000	LABORATORY	1,196,181	1,491,828	2,688,009	-207	2,687,802	60.00
64.00	06400	INTRAVENOUS THERAPY	285,153	32,024	317,177	-47	317,130	64.00
65.00	06500	RESPIRATORY THERAPY	663,157	85,040	748,197	-52,209	695,988	65.00
66.00	06600	PHYSICAL THERAPY	1,103,816	99,438	1,203,254	0	1,203,254	66.00
67.00	06700	OCCUPATIONAL THERAPY	384,071	3,256	387,327	0	387,327	67.00
68.00	06800	SPEECH PATHOLOGY	168,180	642	168,822	0	168,822	68.00
69.00	06900	ELECTROCARDIOLOGY	286,247	133,199	419,446	-139	419,307	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	197,625	197,625	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	556,640	556,640	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,664,292	1,664,292	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	208,526	153,106	361,632	0	361,632	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	17	17	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,471,941	3,343,062	5,815,003	-7,554	5,807,449	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		597,157	597,157	-597,157	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,619,206	33,840,076	53,459,282	0	53,459,282	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	568	568	0	568	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	19,619,206	33,840,644	53,459,850	0	53,459,850	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/23/2024 12:01 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-640,560	4,275,367		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	122,268	2,458,658		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-28,835	6,051,247		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,116,845	8,742,739		5.00
7.00	00700	OPERATION OF PLANT	-9,402	2,070,194		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	210,117		8.00
9.00	00900	HOUSEKEEPING	0	690,707		9.00
10.00	01000	DIETARY	0	351,068		10.00
11.00	01100	CAFETERIA	-226,076	353,926		11.00
13.00	01300	NURSING ADMINISTRATION	-260	859,931		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	213,099		14.00
15.00	01500	PHARMACY	0	642,642		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,323	546,012		16.00
17.00	01700	SOCIAL SERVICE	0	72,763		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-894,045	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-334,364	3,651,135		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-330	1,233,906		50.00
53.00	05300	ANESTHESIOLOGY	0	24,111		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,411,603		54.00
60.00	06000	LABORATORY	0	2,687,802		60.00
64.00	06400	INTRAVENOUS THERAPY	0	317,130		64.00
65.00	06500	RESPIRATORY THERAPY	0	695,988		65.00
66.00	06600	PHYSICAL THERAPY	-1,192	1,202,062		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	387,327		67.00
68.00	06800	SPEECH PATHOLOGY	0	168,822		68.00
69.00	06900	ELECTROCARDIOLOGY	-116,023	303,284		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	197,625		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	556,640		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,664,292		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-57,423	304,209		76.00
76.01	03950	DIABETIC EDUCATION	0	17		76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-2,212,244	3,595,205		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,519,654	46,939,628		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	568		192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,519,654	46,940,196		200.00

RECLASSIFICATIONS | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/23/2024 12:01 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	389,868	190,134		1.00
2.00	DIABETIC EDUCATION	76.01	17	0		2.00
	0		389,885	190,134		
	B - DRUG EXPENSE					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,664,292		1.00
2.00	EMERGENCY	91.00	0	211		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
	0		0	1,664,503		
	C - IMPLANTS & MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	197,625		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	556,640		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	0		0	754,265		
	D - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	57,966		1.00
	0		0	57,966		
	E - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	677,348		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	68,154		2.00
	0		0	745,502		
	F - BOND AMORTIZATION EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	148,345		1.00
	0		0	148,345		
	G - CRNA BENEFITS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	14,801		1.00
	0		0	14,801		
500.00	Grand Total: Increases		389,885	3,575,516		500.00

RECLASSIFICATIONS | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/23/2024 12:01 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA EXPENSE					
1.00	DIETARY	10.00	389,885	190,134	0	1.00
2.00		0.00	0	0	0	2.00
	0		389,885	190,134		
	B - DRUG EXPENSE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,786	0	1.00
2.00	PHARMACY	15.00	0	1,649,000	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	433	0	3.00
4.00	OPERATING ROOM	50.00	0	1,438	0	4.00
5.00	ANESTHESIOLOGY	53.00	0	2,425	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,109	0	6.00
7.00	LABORATORY	60.00	0	39	0	7.00
8.00	INTRAVENOUS THERAPY	64.00	0	47	0	8.00
9.00	RESPIRATORY THERAPY	65.00	0	87	0	9.00
10.00	ELECTROCARDIOLOGY	69.00	0	139	0	10.00
	0		0	1,664,503		
	C - IMPLANTS & MEDICAL SUPPLIES					
1.00	OPERATING ROOM	50.00	0	667,277	0	1.00
2.00	ANESTHESIOLOGY	53.00	0	26,258	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	299	0	3.00
4.00	LABORATORY	60.00	0	168	0	4.00
5.00	RESPIRATORY THERAPY	65.00	0	52,122	0	5.00
6.00	EMERGENCY	91.00	0	7,765	0	6.00
7.00	OPERATION OF PLANT	7.00	0	376	0	7.00
	0		0	754,265		
	D - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	57,966	0	1.00
	0		0	57,966		
	E - INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	745,502	11	1.00
2.00		0.00	0	0	11	2.00
	0		0	745,502		
	F - BOND AMORTIZATION EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	148,345	14	1.00
	0		0	148,345		
	G - CRNA BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	14,801	0	1.00
	0		0	14,801		
500.00	Grand Total: Decreases		389,885	3,575,516		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 2/23/2024 12:01 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	948,070	0	0	0	0	1.00
2.00	Land Improvements	3,837,619	0	0	0	0	2.00
3.00	Buildings and Fixtures	49,499,336	14,698,448	0	14,698,448	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	20,206,662	4,032,872	0	4,032,872	667,998	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	74,491,687	18,731,320	0	18,731,320	667,998	8.00
9.00	Reconciling Items	-19,442,543	17,758,980	0	17,758,980	0	9.00
10.00	Total (line 8 minus line 9)	93,934,230	972,340	0	972,340	667,998	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	948,070	0	1.00
2.00	Land Improvements	3,837,619	0	2.00
3.00	Buildings and Fixtures	64,197,784	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	23,571,536	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	92,555,009	0	8.00
9.00	Reconciling Items	-1,683,563	0	9.00
10.00	Total (line 8 minus line 9)	94,238,572	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 2/23/2024 12:01 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	4,343,721	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,253,473	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,597,194	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	4,343,721	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,253,473	2.00
3.00	Total (sum of lines 1-2)	0	6,597,194	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 2/23/2024 12:01 pm

	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	68,983,473	0	68,983,473	0.745324	43,203	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	23,571,536	0	23,571,536	0.254676	14,763	2.00
3.00	Total (sum of lines 1-2)	92,555,009	0	92,555,009	1.000000	57,966	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	43,203	4,380,509	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	14,763	2,443,895	0	2.00
3.00	Total (sum of lines 1-2)	0	0	57,966	6,824,404	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	0	43,203	0	-148,345	4,275,367	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	14,763	0	0	2,458,658	2.00
3.00	Total (sum of lines 1-2)	0	57,966	0	-148,345	6,734,025	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/23/2024 12:01 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-677,348	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-68,154	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-71,230	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,140	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-9,402	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,771,050			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	-317,387			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-226,076	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,323	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	-1,192	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-894,045	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
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	MISC INCOME - A&G	B	-1,906	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/23/2024 12:01 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISC INCOME - OR	B	-330	OPERATING ROOM	50.00	0	33.01
34.00	PROVIDER TAX	A	-1,693,080	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	MUTUAL FUND TRUSTEE FEES	A	198,284	ADMINISTRATIVE & GENERAL	5.00	0	34.01
35.00	ADVERTISING EXPENSE	A	-2,964	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	LOBBYING EXPENSE	A	-20,249	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	NONPATIENT CARE RELATED TRAVEL	A	-260	NURSING ADMINISTRATION	13.00	0	37.00
37.01	NONPATIENT CARE RELATED TRAVEL	A	-38,189	ADULTS & PEDIATRICS	30.00	0	37.01
37.02	NONPATIENT CARE RELATED TRAVEL	A	-57,423	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	37.02
37.03	NONPATIENT CARE RELATED TRAVEL	A	-13,392	EMERGENCY	91.00	0	37.03
38.00	INVESTMENT MGT FEES	A	151,202	ADMINISTRATIVE & GENERAL	5.00	0	38.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,519,654				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: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 2/23/2024 12:01 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HO CAPITAL - BLDG DIRECT	6,755	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO CAPITAL - MME DIRECT	69,794	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HO CAPITAL - BLDG POOLED	30,033	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO CAPITAL - MME POOLED	120,628	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HO INTEREST EXPENSE	71,230	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	HO MANAGEMENT OPERATING	3,773,966	4,360,958	4.02
4.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	2,617,222	2,646,057	4.03
4.04	60.00	LABORATORY	LABORATORY EXPENSES - MMC	180,260	180,260	4.04
4.05	54.00	RADIOLOGY-DIAGNOSTIC	ISOTOPE EXPENSES - DMH	23,352	23,352	4.05
4.06	4.00	EMPLOYEE BENEFITS DEPARTMENT	EAP PROGRAM - MHS	10,262	10,262	4.06
4.07	4.00	EMPLOYEE BENEFITS DEPARTMENT	TELEHEALTH PSYCHIATRICE RESP	24,924	24,924	4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			6,928,426	7,245,813	5.00

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

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

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

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

6.00	B		0.00	MEMORIAL HEALTH	100.00	6.00
7.00	B		0.00	MEMORIAL MD CTR	0.00	7.00
8.00	B		0.00	ABRAHAM LINCOLN	0.00	8.00
9.00	B		0.00	MEMORIAL VNA	0.00	9.00
10.00	B		0.00	PASSAVANT	0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 2/23/2024 12:01 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	6,755	9		1.00
2.00	69,794	9		2.00
3.00	30,033	9		3.00
4.00	120,628	9		4.00
4.01	71,230	0		4.01
4.02	-586,992	0		4.02
4.03	-28,835	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
5.00	-317,387			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	HOSPITAL		7.00
8.00	HOSPITAL		8.00
9.00	HOME HEALTH		9.00
10.00	HOSPITAL		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: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 2/23/2024 12:01 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	160,000	160,000	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	296,175	296,175	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	116,023	116,023	0	0	0	3.00
4.00	91.00	EMERGENCY	2,931,914	2,198,852	733,062	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,504,112	2,771,050	733,062		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	160,000		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	296,175		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	116,023		3.00
4.00	91.00	EMERGENCY	0	0	0	2,198,852		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,771,050		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1339	Period: From 10/01/2022 To 09/30/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/23/2024 12:01 pm

Physical Therapy — Cost

							1.00	
	PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)						12	1.00
2.00	Line 1 multiplied by 15 hours per week						180	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						58	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						6.55	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	0.00	394.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	0.00	72.18	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	0.00	0.00	36.09				11.00
12.00	Number of travel hours (provider site)	0	0	0				12.00
12.01	Number of travel hours (offsite)	0	0	0				12.01
13.00	Number of miles driven (provider site)	0	0	0				13.00
13.01	Number of miles driven (offsite)	0	0	0				13.01
							1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						0	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)						28,439	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						28,439	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						28,439	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						0	22.00
23.00	Total salary equivalency (see instructions)						28,439	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
	Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)						0	24.00
25.00	Assistants (line 4 times column 3, line 11)						2,093	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						2,093	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						380	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						2,473	28.00
	Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						2,473	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
	Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
	Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/23/2024 12:01 pm

Physical Therapy | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	8.75	0.00	0.00	8.75	47.00
48.00	Overtime rate (see instructions)	0.00	108.27	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	947.36	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	100.00	0.00	0.00	100.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	2,080.00	0.00	0.00	2,080.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	0.00	72.18	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	150,134	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	947	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	632	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	315	0	0	315	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	28,439		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	2,473		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	315		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	31,227		63.00
64.00	Total cost of outside supplier services (from your records)	32,419		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	1,192		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	2,093		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	380		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	2,473		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	380		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	380		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/23/2024 12:01 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,275,367	4,275,367				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,458,658		2,458,658			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,051,247	0	0	6,051,247		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,742,739	409,141	548,790	637,585	10,338,255	5.00
7.00	00700	OPERATION OF PLANT	2,070,194	1,179,881	350,675	284,773	3,885,523	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	210,117	0	0	11,309	221,426	8.00
9.00	00900	HOUSEKEEPING	690,707	76,805	4,601	184,738	956,851	9.00
10.00	01000	DIETARY	351,068	3,681	52,432	76,615	483,796	10.00
11.00	01100	CAFETERIA	353,926	153,610	86,622	126,577	720,735	11.00
13.00	01300	NURSING ADMINISTRATION	859,931	7,609	13,417	269,787	1,150,744	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	213,099	101,613	0	34,308	349,020	14.00
15.00	01500	PHARMACY	642,642	83,208	104,105	185,959	1,015,914	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	546,012	33,128	0	178,061	757,201	16.00
17.00	01700	SOCIAL SERVICE	72,763	3,990	0	23,624	100,377	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,651,135	650,784	78,327	1,034,930	5,415,176	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,233,906	410,193	261,344	258,237	2,163,680	50.00
53.00	05300	ANESTHESIOLOGY	24,111	8,197	56,460	0	88,768	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,411,603	236,446	671,287	547,635	3,866,971	54.00
60.00	06000	LABORATORY	2,687,802	146,743	62,529	388,359	3,285,433	60.00
64.00	06400	INTRAVENOUS THERAPY	317,130	97,684	3,828	92,579	511,221	64.00
65.00	06500	RESPIRATORY THERAPY	695,988	35,943	18,917	215,305	966,153	65.00
66.00	06600	PHYSICAL THERAPY	1,202,062	210,247	11,005	358,372	1,781,686	66.00
67.00	06700	OCCUPATIONAL THERAPY	387,327	51,409	0	124,695	563,431	67.00
68.00	06800	SPEECH PATHOLOGY	168,822	3,557	0	54,602	226,981	68.00
69.00	06900	ELECTROCARDIOLOGY	303,284	33,964	23,225	92,935	453,408	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	197,625	0	0	0	197,625	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	556,640	0	0	0	556,640	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,664,292	0	0	0	1,664,292	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	304,209	71,392	0	67,701	443,302	76.00
76.01	03950	DIABETIC EDUCATION	17	0	0	6	23	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,595,205	242,169	103,896	802,555	4,743,825	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,939,628	4,251,394	2,451,460	6,051,247	46,908,457	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,973	0	0	23,973	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	568	0	7,198	0	7,766	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	46,940,196	4,275,367	2,458,658	6,051,247	46,940,196	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/23/2024 12:01 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,338,255					5.00
7.00	00700	OPERATION OF PLANT	1,097,470	4,982,993				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	62,542	0	283,968			8.00
9.00	00900	HOUSEKEEPING	270,264	142,468	5,602	1,375,185		9.00
10.00	01000	DIETARY	136,649	6,828	3,715	1,940	632,928	10.00
11.00	01100	CAFETERIA	203,572	284,936	0	80,950	0	11.00
13.00	01300	NURSING ADMINISTRATION	325,029	14,115	0	4,010	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	98,581	188,485	898	53,548	0	14.00
15.00	01500	PHARMACY	286,946	154,345	0	43,849	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	213,872	61,451	0	17,458	0	16.00
17.00	01700	SOCIAL SERVICE	28,352	7,402	0	2,103	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,529,519	1,207,163	140,068	342,952	632,928	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	611,134	760,881	22,411	216,165	0	50.00
53.00	05300	ANESTHESIOLOGY	25,073	15,205	0	4,320	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,092,230	438,592	21,516	124,603	0	54.00
60.00	06000	LABORATORY	927,974	272,198	448	77,331	0	60.00
64.00	06400	INTRAVENOUS THERAPY	144,395	181,198	0	51,478	0	64.00
65.00	06500	RESPIRATORY THERAPY	272,891	66,672	0	18,942	0	65.00
66.00	06600	PHYSICAL THERAPY	503,239	389,994	19,160	110,797	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	159,142	95,361	0	27,092	0	67.00
68.00	06800	SPEECH PATHOLOGY	64,111	6,598	0	1,875	0	68.00
69.00	06900	ELECTROCARDIOLOGY	128,066	63,000	0	17,898	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	55,819	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	157,224	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	470,081	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	125,211	132,427	0	37,622	0	76.00
76.01	03950	DIABETIC EDUCATION	6	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,339,898	449,207	70,033	127,619	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,329,290	4,938,526	283,851	1,362,552	632,928	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,771	44,467	0	12,633	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,194	0	117	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	10,338,255	4,982,993	283,968	1,375,185	632,928	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/23/2024 12:01 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,290,193					11.00
13.00	01300	NURSING ADMINISTRATION	64,069	1,557,967				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	128	0	690,660			14.00
15.00	01500	PHARMACY	41,943	0	3,366	1,546,363		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	79,236	0	0	0	1,129,218	16.00
17.00	01700	SOCIAL SERVICE	7,375	20,108	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	284,686	774,270	53,863	0	162,578	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	70,161	190,759	86,221	0	97,547	50.00
53.00	05300	ANESTHESIOLOGY	18,246	49,688	3,250	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	135,994	0	25,043	0	103,121	54.00
60.00	06000	LABORATORY	111,527	0	224,808	0	113,340	60.00
64.00	06400	INTRAVENOUS THERAPY	24,050	0	9,279	0	25,548	64.00
65.00	06500	RESPIRATORY THERAPY	62,273	0	0	0	16,722	65.00
66.00	06600	PHYSICAL THERAPY	89,273	0	866	0	21,832	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,431	0	189	0	6,968	67.00
68.00	06800	SPEECH PATHOLOGY	14,462	0	45	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	42,745	0	1,304	0	36,232	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	60,223	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	169,627	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,546,363	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	21,260	0	121	0	14,864	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	192,334	523,142	52,443	0	530,466	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,290,193	1,557,967	690,648	1,546,363	1,129,218	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	12	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,290,193	1,557,967	690,660	1,546,363	1,129,218	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/23/2024 12:01 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	165,717					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	165,717	0	10,708,920	-200,378	10,508,542	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	4,218,959	1,530	4,220,489	50.00
53.00	05300	ANESTHESIOLOGY	0	0	204,550	0	204,550	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	5,808,070	0	5,808,070	54.00
60.00	06000	LABORATORY	0	0	5,013,059	0	5,013,059	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	947,169	198,848	1,146,017	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,403,653	0	1,403,653	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,916,847	0	2,916,847	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	882,614	0	882,614	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	314,072	0	314,072	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	742,653	0	742,653	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	313,667	0	313,667	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	883,491	0	883,491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,680,736	0	3,680,736	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	774,807	0	774,807	76.00
76.01	03950	DIABETIC EDUCATION	0	0	29	0	29	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	8,028,967	0	8,028,967	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	165,717	0	46,842,263	0	46,842,263	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	87,844	0	87,844	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	10,089	0	10,089	192.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	165,717	0	46,940,196	0	46,940,196	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/23/2024 12:01 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	409,141	548,790	957,931	0	5.00
7.00	00700	OPERATION OF PLANT	13,790	1,179,881	350,675	1,544,346	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	76,805	4,601	81,406	0	9.00
10.00	01000	DIETARY	0	3,681	52,432	56,113	0	10.00
11.00	01100	CAFETERIA	0	153,610	86,622	240,232	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,609	13,417	21,026	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	682	101,613	0	102,295	0	14.00
15.00	01500	PHARMACY	0	83,208	104,105	187,313	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	33,128	0	33,128	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,990	0	3,990	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,084	650,784	78,327	769,195	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	559	410,193	261,344	672,096	0	50.00
53.00	05300	ANESTHESIOLOGY	0	8,197	56,460	64,657	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	236,446	671,287	907,733	0	54.00
60.00	06000	LABORATORY	0	146,743	62,529	209,272	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	97,684	3,828	101,512	0	64.00
65.00	06500	RESPIRATORY THERAPY	720	35,943	18,917	55,580	0	65.00
66.00	06600	PHYSICAL THERAPY	0	210,247	11,005	221,252	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	51,409	0	51,409	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,557	0	3,557	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	33,964	23,225	57,189	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	71,392	0	71,392	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	242,169	103,896	346,065	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	55,835	4,251,394	2,451,460	6,758,689	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,973	0	23,973	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	7,198	7,198	0	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	55,835	4,275,367	2,458,658	6,789,860	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/23/2024 12:01 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	957,931					5.00
7.00	00700	OPERATION OF PLANT	101,692	1,646,038				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,795	0	5,795			8.00
9.00	00900	HOUSEKEEPING	25,043	47,062	114	153,625		9.00
10.00	01000	DIETARY	12,662	2,255	76	217	71,323	10.00
11.00	01100	CAFETERIA	18,863	94,123	0	9,043	0	11.00
13.00	01300	NURSING ADMINISTRATION	30,117	4,663	0	448	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,135	62,262	18	5,982	0	14.00
15.00	01500	PHARMACY	26,589	50,985	0	4,898	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,817	20,299	0	1,950	0	16.00
17.00	01700	SOCIAL SERVICE	2,627	2,445	0	235	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	141,712	398,762	2,860	38,312	71,323	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	56,628	251,343	457	24,148	0	50.00
53.00	05300	ANESTHESIOLOGY	2,323	5,023	0	483	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	101,206	144,881	439	13,920	0	54.00
60.00	06000	LABORATORY	85,986	89,916	9	8,639	0	60.00
64.00	06400	INTRAVENOUS THERAPY	13,380	59,855	0	5,751	0	64.00
65.00	06500	RESPIRATORY THERAPY	25,286	22,024	0	2,116	0	65.00
66.00	06600	PHYSICAL THERAPY	46,630	128,827	391	12,377	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,746	31,501	0	3,027	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,941	2,180	0	209	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,867	20,811	0	1,999	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,172	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,568	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,558	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	11,602	43,745	0	4,203	0	76.00
76.01	03950	DIABETIC EDUCATION	1	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	124,155	148,387	1,429	14,257	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	957,101	1,631,349	5,793	152,214	71,323	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	627	14,689	0	1,411	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	203	0	2	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	957,931	1,646,038	5,795	153,625	71,323	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/23/2024 12:01 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	362,261					11.00
13.00	01300	NURSING ADMINISTRATION	17,989	74,243				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	36	0	179,728			14.00
15.00	01500	PHARMACY	11,777	0	876	282,438		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,248	0	0	0	97,442	16.00
17.00	01700	SOCIAL SERVICE	2,071	958	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	79,934	36,897	14,017	0	14,029	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,700	9,090	22,437	0	8,417	50.00
53.00	05300	ANESTHESIOLOGY	5,123	2,368	846	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,184	0	6,517	0	8,898	54.00
60.00	06000	LABORATORY	31,315	0	58,500	0	9,780	60.00
64.00	06400	INTRAVENOUS THERAPY	6,753	0	2,415	0	2,205	64.00
65.00	06500	RESPIRATORY THERAPY	17,485	0	0	0	1,443	65.00
66.00	06600	PHYSICAL THERAPY	25,066	0	225	0	1,884	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,544	0	49	0	601	67.00
68.00	06800	SPEECH PATHOLOGY	4,061	0	12	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12,002	0	339	0	3,126	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	15,672	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	44,142	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	282,438	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5,969	0	31	0	1,283	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	54,004	24,930	13,647	0	45,776	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	362,261	74,243	179,725	282,438	97,442	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	3	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	362,261	74,243	179,728	282,438	97,442	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/23/2024 12:01 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	12,326					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,326		1,579,367	0	1,579,367	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		1,064,316	0	1,064,316	50.00
53.00	05300	ANESTHESIOLOGY	0		80,823	0	80,823	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		1,221,778	0	1,221,778	54.00
60.00	06000	LABORATORY	0		493,417	0	493,417	60.00
64.00	06400	INTRAVENOUS THERAPY	0		191,871	0	191,871	64.00
65.00	06500	RESPIRATORY THERAPY	0		123,934	0	123,934	65.00
66.00	06600	PHYSICAL THERAPY	0		436,652	0	436,652	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		109,877	0	109,877	67.00
68.00	06800	SPEECH PATHOLOGY	0		15,960	0	15,960	68.00
69.00	06900	ELECTROCARDIOLOGY	0		107,333	0	107,333	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		20,844	0	20,844	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		58,710	0	58,710	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		325,996	0	325,996	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		138,225	0	138,225	76.00
76.01	03950	DIABETIC EDUCATION	0		1	0	1	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0		772,650	0	772,650	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,326	0	6,741,754	0	6,741,754	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		40,700	0	40,700	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		7,406	0	7,406	192.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	12,326	0	6,789,860	0	6,789,860	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/23/2024 12:01 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	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	138,217					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,443,895				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	18,638,379			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,227	545,495	1,963,818	-10,338,255	36,601,941	5.00
7.00	00700	OPERATION OF PLANT	38,144	348,569	877,125	0	3,885,523	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	34,832	0	221,426	8.00
9.00	00900	HOUSEKEEPING	2,483	4,573	569,008	0	956,851	9.00
10.00	01000	DIETARY	119	52,117	235,982	0	483,796	10.00
11.00	01100	CAFETERIA	4,966	86,102	389,868	0	720,735	11.00
13.00	01300	NURSING ADMINISTRATION	246	13,336	830,968	0	1,150,744	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,285	0	105,671	0	349,020	14.00
15.00	01500	PHARMACY	2,690	103,480	572,771	0	1,015,914	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,071	0	548,443	0	757,201	16.00
17.00	01700	SOCIAL SERVICE	129	0	72,763	0	100,377	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,039	77,857	3,187,684	0	5,415,176	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,261	259,775	795,394	0	2,163,680	50.00
53.00	05300	ANESTHESIOLOGY	265	56,121	0	0	88,768	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,644	667,256	1,686,763	0	3,866,971	54.00
60.00	06000	LABORATORY	4,744	62,154	1,196,181	0	3,285,433	60.00
64.00	06400	INTRAVENOUS THERAPY	3,158	3,805	285,153	0	511,221	64.00
65.00	06500	RESPIRATORY THERAPY	1,162	18,803	663,157	0	966,153	65.00
66.00	06600	PHYSICAL THERAPY	6,797	10,939	1,103,816	0	1,781,686	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,662	0	384,071	0	563,431	67.00
68.00	06800	SPEECH PATHOLOGY	115	0	168,180	0	226,981	68.00
69.00	06900	ELECTROCARDIOLOGY	1,098	23,086	286,247	0	453,408	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	197,625	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	556,640	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,664,292	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,308	0	208,526	0	443,302	76.00
76.01	03950	DIABETIC EDUCATION	0	0	17	0	23	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,829	103,272	2,471,941	0	4,743,825	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	137,442	2,436,740	18,638,379	-10,338,255	36,570,202	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	775	0	0	0	23,973	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,155	0	0	7,766	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,275,367	2,458,658	6,051,247		10,338,255	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.932280	1.006041	0.324666		0.282451	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		957,931	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.026172	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: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/23/2024 12:01 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			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	86,846					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	221,686				8.00
9.00	00900	HOUSEKEEPING	2,483	4,373	84,363			9.00
10.00	01000	DIETARY	119	2,900	119	34,738		10.00
11.00	01100	CAFETERIA	4,966	0	4,966	0	40,235	11.00
13.00	01300	NURSING ADMINISTRATION	246	0	246	0	1,998	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,285	701	3,285	0	4	14.00
15.00	01500	PHARMACY	2,690	0	2,690	0	1,308	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,071	0	1,071	0	2,471	16.00
17.00	01700	SOCIAL SERVICE	129	0	129	0	230	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,039	109,347	21,039	34,738	8,878	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,261	17,496	13,261	0	2,188	50.00
53.00	05300	ANESTHESIOLOGY	265	0	265	0	569	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,644	16,797	7,644	0	4,241	54.00
60.00	06000	LABORATORY	4,744	350	4,744	0	3,478	60.00
64.00	06400	INTRAVENOUS THERAPY	3,158	0	3,158	0	750	64.00
65.00	06500	RESPIRATORY THERAPY	1,162	0	1,162	0	1,942	65.00
66.00	06600	PHYSICAL THERAPY	6,797	14,958	6,797	0	2,784	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,662	0	1,662	0	949	67.00
68.00	06800	SPEECH PATHOLOGY	115	0	115	0	451	68.00
69.00	06900	ELECTROCARDIOLOGY	1,098	0	1,098	0	1,333	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,308	0	2,308	0	663	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,829	54,673	7,829	0	5,998	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	86,071	221,595	83,588	34,738	40,235	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	775	0	775	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	91	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,982,993	283,968	1,375,185	632,928	1,290,193	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	57.377346	1.280947	16.300807	18.220047	32.066435	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,646,038	5,795	153,625	71,323	362,261	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	18.953527	0.026141	1.821000	2.053169	9.003629	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: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/23/2024 12:01 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			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	166,431					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,266,445				14.00
15.00	01500	PHARMACY	0	11,047	1,664,292			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	2,431		16.00
17.00	01700	SOCIAL SERVICE	2,148	0	0	0	2,148	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	82,712	176,754	0	350	2,148	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,378	282,938	0	210	0	50.00
53.00	05300	ANESTHESIOLOGY	5,308	10,666	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	82,180	0	222	0	54.00
60.00	06000	LABORATORY	0	737,724	0	244	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	30,450	0	55	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	36	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,841	0	47	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	619	0	15	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	149	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,280	0	78	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	197,625	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	556,641	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,664,292	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	396	0	32	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	55,885	172,096	0	1,142	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	166,431	2,266,406	1,664,292	2,431	2,148	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	39	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,557,967	690,660	1,546,363	1,129,218	165,717	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.361039	0.304733	0.929142	464.507610	77.149441	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	74,243	179,728	282,438	97,442	12,326	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.446089	0.079300	0.169705	40.083093	5.738361	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: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/23/2024 12:01 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	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		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	76.00
76.01	03950	DIABETIC EDUCATION	0	76.01
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-2 | Date/Time Prepared: 2/23/2024 12:01 pm

		Description	Worksheet CODE	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		ADULTS & PEDIATRICS	1	30.00	-200,378	7.00
8.00		OPERATING ROOM	1	50.00	1,530	8.00
9.00		IV THERAPY	1	64.00	198,848	9.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/23/2024 12:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,508,542		10,508,542	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,220,489		4,220,489	0	0	50.00
53.00	05300	ANESTHESIOLOGY	204,550		204,550	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,808,070		5,808,070	0	0	54.00
60.00	06000	LABORATORY	5,013,059		5,013,059	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,146,017		1,146,017	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,403,653	0	1,403,653	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,916,847	0	2,916,847	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	882,614	0	882,614	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	314,072	0	314,072	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	742,653		742,653	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	313,667		313,667	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	883,491		883,491	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,680,736		3,680,736	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	774,807		774,807	0	0	76.00
76.01	03950	DIABETIC EDUCATION	29		29	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,028,967		8,028,967	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	942,080		942,080		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	47,784,343	0	47,784,343	0	0	200.00
201.00		Less Observation Beds	942,080		942,080		0	201.00
202.00		Total (see instructions)	46,842,263	0	46,842,263	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/23/2024 12:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,134,006		7,134,006			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	96,706	7,758,540	7,855,246	0.537283	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	21,133	1,274,772	1,295,905	0.157843	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,539,356	53,968,572	55,507,928	0.104635	0.000000	54.00
60.00	06000	LABORATORY	3,092,047	16,509,539	19,601,586	0.255748	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	33,945	2,576,151	2,610,096	0.439071	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,135,372	2,543,563	3,678,935	0.381538	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	912,036	5,398,491	6,310,527	0.462219	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	876,986	1,147,274	2,024,260	0.436018	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	221,869	850,481	1,072,350	0.292882	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	492,374	5,329,611	5,821,985	0.127560	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	620,088	1,419,452	2,039,540	0.153793	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	129,063	4,485,603	4,614,666	0.191453	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,769,037	11,033,961	13,802,998	0.266662	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	801,227	801,227	0.967026	0.000000	76.00
76.01	03950	DIABETIC EDUCATION	0	630	630	0.046032	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	523,806	21,721,415	22,245,221	0.360930	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	52,118	2,045,893	2,098,011	0.449035	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	19,649,942	138,865,175	158,515,117			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	19,649,942	138,865,175	158,515,117			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/23/2024 12:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
76.01	03950	DIABETIC EDUCATION	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/23/2024 12:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,064,316	7,855,246	0.135491	54,062	7,325	50.00
53.00	05300	ANESTHESIOLOGY	80,823	1,295,905	0.062368	11,292	704	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,221,778	55,507,928	0.022011	499,394	10,992	54.00
60.00	06000	LABORATORY	493,417	19,601,586	0.025172	828,074	20,844	60.00
64.00	06400	INTRAVENOUS THERAPY	191,871	2,610,096	0.073511	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	123,934	3,678,935	0.033687	317,090	10,682	65.00
66.00	06600	PHYSICAL THERAPY	436,652	6,310,527	0.069194	42,034	2,909	66.00
67.00	06700	OCCUPATIONAL THERAPY	109,877	2,024,260	0.054280	34,704	1,884	67.00
68.00	06800	SPEECH PATHOLOGY	15,960	1,072,350	0.014883	31,950	476	68.00
69.00	06900	ELECTROCARDIOLOGY	107,333	5,821,985	0.018436	209,430	3,861	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,844	2,039,540	0.010220	151,318	1,546	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	58,710	4,614,666	0.012722	112,957	1,437	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	325,996	13,802,998	0.023618	599,798	14,166	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	138,225	801,227	0.172517	0	0	76.00
76.01	03950	DIABETIC EDUCATION	1	630	0.001587	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	772,650	22,245,221	0.034733	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	141,589	2,098,011	0.067487	0	0	92.00
200.00		Total (lines 50 through 199)	5,303,976	151,381,111		2,892,103	76,826	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/23/2024 12:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
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: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/23/2024 12:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	7,855,246	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,295,905	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	55,507,928	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	19,601,586	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,610,096	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,678,935	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,310,527	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,024,260	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,072,350	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,821,985	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,039,540	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,614,666	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,802,998	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	801,227	0.000000	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	630	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	22,245,221	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,098,011	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	151,381,111		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/23/2024 12:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	54,062	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	11,292	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	499,394	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	828,074	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	317,090	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	42,034	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	34,704	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	31,950	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	209,430	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	151,318	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	112,957	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	599,798	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
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)		2,892,103	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/23/2024 12:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.537283	0	2,595,145	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.157843	0	384,779	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104635	0	14,979,110	0	0	54.00
60.00	06000	LABORATORY	0.255748	0	4,203,100	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.439071	0	1,188,576	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.381538	0	693,734	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.462219	0	1,543,931	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.436018	0	205,231	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.292882	0	80,920	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.127560	0	1,905,779	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.153793	0	449,352	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.191453	0	1,868,339	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.266662	0	7,366,323	1,094	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.967026	0	466,557	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.046032	0	504	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.360930	0	4,619,745	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.449035	0	691,588	0	0	92.00
200.00		Subtotal (see instructions)		0	43,242,713	1,094	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	43,242,713	1,094	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/23/2024 12:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,394,327	0		50.00
53.00	05300	ANESTHESIOLOGY	60,735	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,567,339	0		54.00
60.00	06000	LABORATORY	1,074,934	0		60.00
64.00	06400	INTRAVENOUS THERAPY	521,869	0		64.00
65.00	06500	RESPIRATORY THERAPY	264,686	0		65.00
66.00	06600	PHYSICAL THERAPY	713,634	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	89,484	0		67.00
68.00	06800	SPEECH PATHOLOGY	23,700	0		68.00
69.00	06900	ELECTROCARDIOLOGY	243,101	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	69,107	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	357,699	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,964,318	292		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	451,173	0		76.00
76.01	03950	DIABETIC EDUCATION	23	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,667,405	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	310,547	0		92.00
200.00		Subtotal (see instructions)	10,774,081	292		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	10,774,081	292		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/23/2024 12:01 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,130	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,035	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)	1,512	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	989	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)	2,772	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	74	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)	260	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	883	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)	780	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)	1,824	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	188.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	208.70	20.00
21.00	Total general inpatient routine service cost (see instructions)	10,508,542	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)	13,945	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)	54,262	25.00
26.00	Total swing-bed cost (see instructions)	6,842,896	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,665,646	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)	3,665,646	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)	1,801.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,590,548	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)	1,590,548	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/23/2024 12:01 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	691,318	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	2,281,866	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	1,405,014	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	3,285,571	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	4,690,585	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)	523	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,801.30	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	942,080	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/23/2024 12:01 pm

Title XVIII | Hospital | Cost

	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	1,579,367	10,508,542	0.150294	942,080	141,589	90.00
91.00	Nursing Program cost	0	10,508,542	0.000000	942,080	0	91.00
92.00	Allied health cost	0	10,508,542	0.000000	942,080	0	92.00
93.00	All other Medical Education	0	10,508,542	0.000000	942,080	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/23/2024 12:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,607,206		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.537283	54,062	29,047	50.00
53.00	05300	ANESTHESIOLOGY	0.157843	11,292	1,782	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104635	499,394	52,254	54.00
60.00	06000	LABORATORY	0.255748	828,074	211,778	60.00
64.00	06400	INTRAVENOUS THERAPY	0.439071	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.381538	317,090	120,982	65.00
66.00	06600	PHYSICAL THERAPY	0.462219	42,034	19,429	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.436018	34,704	15,132	67.00
68.00	06800	SPEECH PATHOLOGY	0.292882	31,950	9,358	68.00
69.00	06900	ELECTROCARDIOLOGY	0.127560	209,430	26,715	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.153793	151,318	23,272	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.191453	112,957	21,626	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.266662	599,798	159,943	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.967026	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.046032	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.360930	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.449035	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,892,103	691,318	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,892,103		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1339 | Component CCN: 14-Z339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/23/2024 12:01 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.537283	5,892	3,166	50.00
53.00	05300	ANESTHESIOLOGY	0.157843	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104635	316,398	33,106	54.00
60.00	06000	LABORATORY	0.255748	967,686	247,484	60.00
64.00	06400	INTRAVENOUS THERAPY	0.439071	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.381538	227,524	86,809	65.00
66.00	06600	PHYSICAL THERAPY	0.462219	539,858	249,533	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.436018	538,027	234,589	67.00
68.00	06800	SPEECH PATHOLOGY	0.292882	77,490	22,695	68.00
69.00	06900	ELECTROCARDIOLOGY	0.127560	49,922	6,368	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.153793	184,153	28,321	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.191453	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.266662	886,201	236,316	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.967026	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.046032	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.360930	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.449035	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,793,151	1,148,387	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)		3,793,151		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1339	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/23/2024 12:01 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	10,774,373	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	10,774,373	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)	10,882,117	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	46,693	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	7,717,921	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,117,503	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	3,117,503	30.00
31.00	Primary payer payments	924	31.00
32.00	Subtotal (line 30 minus line 31)	3,116,579	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	1,248,589	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	811,583	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,076,396	36.00
37.00	Subtotal (see instructions)	3,928,162	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,928,162	40.00
40.01	Sequestration adjustment (see instructions)	78,563	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	3,899,756	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)	-50,157	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1339	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/23/2024 12:01 pm
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/23/2024 12:01 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,842,863		5,238,719	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	09/14/2023	10,986	09/14/2023	1,338,963	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)		-10,986		-1,338,963	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,831,877		3,899,756	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		176,560		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		50,157	6.02
7.00	Total Medicare program liability (see instructions)		2,008,437		3,849,599	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: 14-1339 | Component CCN: 14-Z339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/23/2024 12:01 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,471,783		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		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	09/14/2023	225,258		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)		-225,258		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,246,525		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		443,869		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		5,690,394		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1339	Period: From 10/01/2022 To 09/30/2023	Worksheet E-1 Part II Date/Time Prepared: 2/23/2024 12:01 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1339 | Component CCN: 14-Z339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-2 | Date/Time Prepared: 2/23/2024 12:01 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	4,737,491	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	1,159,871	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	2,604	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	5,897,362	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	5,897,362	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	5,897,362	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	102,012	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	5,795,350	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	17,190	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	11,174	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	16,995	0	18.00
19.00	Total (see instructions)	5,806,524	0	19.00
19.01	Sequestration adjustment (see instructions)	116,130	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	5,246,525	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	443,869	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1339	Period: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part V Date/Time Prepared: 2/23/2024 12:01 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,281,866	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	2,281,866	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,304,685	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,304,685	19.00
20.00	Deductibles (exclude professional component)	300,568	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,004,117	22.00
23.00	Coinsurance	3,600	23.00
24.00	Subtotal (line 22 minus line 23)	2,000,517	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	75,245	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	48,909	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	69,176	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,049,426	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,049,426	30.00
30.01	Sequestration adjustment (see instructions)	40,989	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,831,877	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	176,560	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G | Date/Time Prepared: 2/23/2024 12:01 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,345,456	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	11,174,338	0	0	0	3.00
4.00	Accounts receivable	0	0	0	0	4.00
5.00	Other receivable	734,163	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,443,814	0	0	0	6.00
7.00	Inventory	404,586	0	0	0	7.00
8.00	Prepaid expenses	281,472	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	-282,694	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	11,213,507	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	948,070	0	0	0	12.00
13.00	Land improvements	3,895,629	0	0	0	13.00
14.00	Accumulated depreciation	-2,378,723	0	0	0	14.00
15.00	Buildings	64,197,784	0	0	0	15.00
16.00	Accumulated depreciation	-20,951,994	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	23,571,536	0	0	0	23.00
24.00	Accumulated depreciation	-14,501,438	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	1,625,553	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	56,406,417	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	63,254,897	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	4,172,759	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	67,427,656	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	135,047,580	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,038,316	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,632,380	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	697,130	0	0	0	40.00
41.00	Deferred income	350,144	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	852,433	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,570,403	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	18,472,329	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	18,472,329	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	24,042,732	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	111,004,848				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	111,004,848	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	135,047,580	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-1 | Date/Time Prepared: 2/23/2024 12:01 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		93,384,450		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		17,251,166				2.00
3.00	Total (sum of line 1 and line 2)		110,635,616		0		3.00
4.00	INCREASE IN RESTRICTED NET ASSETS	369,232		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		369,232		0		10.00
11.00	Subtotal (line 3 plus line 10)		111,004,848		0		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)		111,004,848		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	INCREASE IN RESTRICTED NET ASSETS		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: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 2/23/2024 12:01 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,382,990		2,382,990	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	4,376,998		4,376,998	5.00
6.00	Swing bed - NF	388,704		388,704	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)	7,148,692		7,148,692	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	7,148,692		7,148,692	17.00
18.00	Ancillary services	11,979,762	117,268,565	129,248,327	18.00
19.00	Outpatient services	582,181	24,040,119	24,622,300	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	220,092	12,664,852	12,884,944	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	19,930,727	153,973,536	173,904,263	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		53,459,850		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)		53,459,850		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1339 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-3 | Date/Time Prepared: 2/23/2024 12:01 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	173,904,263	1.00
2.00	Less contractual allowances and discounts on patients' accounts	109,380,248	2.00
3.00	Net patient revenues (line 1 minus line 2)	64,524,015	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	53,459,850	4.00
5.00	Net income from service to patients (line 3 minus line 4)	11,064,165	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	563,900	6.00
7.00	Income from investments	783,592	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	226,076	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	4,323	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	30,743	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	3,381	24.00
24.01	CHANGE IN INTEREST IN FOUNDATION	166,022	24.01
24.02	UNREALIZED GAIN ON INVESTMENTS	3,432,800	24.02
24.03	GAIN OF DISPOSAL ON ASSETS	26,666	24.03
24.50	COVID-19 PHE Funding	949,498	24.50
25.00	Total other income (sum of lines 6-24)	6,187,001	25.00
26.00	Total (line 5 plus line 25)	17,251,166	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	17,251,166	29.00